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KATY, TX 77494
(281)368-7878

December 20, 2018

Braidwood Management, Inc.
Attn: Catherine Burnett & Monica Luedecke
20214 Braidwood Drive
Katy, TX 77450

RE: 2018 Changes to Your Plan Document/Summary Plan Description (SPD)

Dear Ms. Burnett & Ms. Luedecke:

The draft of your Employee Benefit Plan Document (also known as the Summary Plan Description "SPD") has been completed for your inspection and consideration. This Plan Document & Summary Plan Description reflects the provisions that you and your Account Manager discussed, and all revisions and modifications from any prior versions are incorporated herein.

Included in your 2018 Plan Document are many changes designed to clarify certain terms of coverage and exclusions in the Plan. The changes include the following modifications and are highlighted in the document for your convenience:

- The percentage to be paid when no code has been established by CMS or any type of repricing was reduced to follow current market billing practices.
- Inpatient Rehabilitation Facility was defined to allow for ease of administration of benefits.
- Specialty Drug was defined to clarify benefits for plan participants.
- Eligibility Terms were clarified to ensure that the term of "Spouse" incorporated the Supreme Court's intent in Obergefell v. Hodges.
- The Special Enrollment Period Section was updated in order to clarify the time frame for each special enrollment window.
- The exclusion regarding driving under the influence was not removed, however it may be removed if requested.
- Several exclusions were modified to simplify various exclusions intent and medical necessity.
- A Pre-Negotiated Cash Option has been added to the schedule of benefits to allow plan participants flexibility to negotiate with providers for lower prices when pursuing medical treatment, however it may be removed if requested.
- Braidwood Management, Inc., as the Plan Sponsor, believes that certain mandates under the Patient Protection and Affordable Care Act violate its religious liberty under the United States Constitution as provided in the *Burwell v. Hobby Lobby* case. As such, the Plan intends to not cover certain preventive services and medications that

have been identified as required by the Patient Protection and Affordable Care Act, specifically any abortion or abortifacient contraceptives. Language regarding this choice has been highlighted throughout the plan document.

If you would like to discuss these changes or make revisions, please contact me or your Account Manager as soon as possible. In addition to the ACA changes listed above, there are other changes that were included for clarification purposes. If you are satisfied with the document, please return this cover letter to our office signed below by the appropriate individual.

Please keep in mind that after the effective date of this Plan, we will be receiving benefit calls from providers and verifying benefits known at that time. Evidenced by your signature below, it is your intent to adopt the plan document in full. **Remember that we cannot begin processing your benefits until your Plan Document & Summary Plan Description is approved, signed, and returned to our office. It is your intent to adopt the plan document as written evidenced by your signature below.**

As the employer plan sponsor, it is your responsibility to ensure all plan participants promptly receive a copy of the signed Plan Document & Summary Plan Description and any amendments. Please contact your Account Manager if you need assistance with distribution. If you have any questions or comments, please do not hesitate to contact me or your Account Manager.

Sincerely,

Kaitlyn Belew
Compliance Attorney

Accepted by: _____ _____

Signature Date

_____

Printed Name

PLAN DOCUMENT & SUMMARY PLAN DESCRIPTION FOR:

Non-Grandfathered Plan

BRAIDWOOD MANAGEMENT
EMPLOYEE BENEFIT PLAN TRUST
Plan B

Effective December 1, 2018

Claims Administered by:

ENTRUST®
INSURANCE AND BENEFIT PROFESSIONALS

You are required to call (877) 463-3435 for hospital Prior Authorization.
Refer to Medical Management Section for details.

Please see Medicare Part D section for important rights you may have regarding Medicare prescription coverage.

This document reflects the medical and/or dental benefits included under your employee benefit plan. If Life and AD&D coverage is also included, each covered employee will receive a separate Life and AD&D Summary Plan Description.

TABLE OF CONTENTS

Important Notice About Balance Billing

When you receive health care services from a network provider, they may refer services related to your treatment to non-network providers, including but not limited to radiologists, anesthesiologists, neonatologists, and pathologists. This may expose you to expenses not covered by your Plan. When this occurs, the difference between what your Plan allows and what the provider charges or accepts may be different because these providers often charge more than this plan will pay. This gap may result in what is called "balance billing." **Any time you receive services from a non-network provider you may be balance billed.** In an attempt to avoid balance billing, you should inquire whenever possible whether the charges of the provider will be satisfied by the Plan's Allowable Amount as stated in the Defined Terms section of this document.

In order to better understand the costs of service, we urge you to ask your provider how much they will charge for the particular service or services before they are rendered. Note that Non-Network providers are subject to reimbursement based on the Plan's Allowable Amount and some providers will seek additional payments from you. For more information about what a provider charges, there are many services available on line, including Healthcare Blue Book (healthcarebluebook.com), Texas Price Point, and others.

INTRODUCTION

This document is a description of the Braidwood Management Employee Benefit Plan Trust (the Plan) sponsored by the Employer shown in Appendix A. The Plan described is designed to protect Plan Participants against catastrophic health expenses. The Plan is subject to and governed by the Employee Retirement Security Act of 1974 (ERISA). **In the event that any term or provision of any other document, including any summary of benefits you have received, conflicts with this Plan Document, the terms of this Plan Document will be controlling with respect to the Plan. Notwithstanding any other provision in this document, this Plan shall at all times comply with the requirements and regulations of the Affordable Care Act (ACA).**

Non-Grandfathered Health Plan Status

The Plan believes it is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). Being a non-grandfathered health plan means that your Plan includes certain consumer protections of the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your Employer or Entrust, Inc., Claims Administrator, at 1-800-436-8787. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

When a person is employed that person's salary pays the expenses of day-to-day living. If an illness or injury occurs, the cost involved could cause financial difficulties. This Plan can ease such financial burdens by providing reimbursement for covered expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the waiting period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility and the like.

Any amendments to the Plan will be implemented on the first of the month following the date the amendment is approved and signed by the Plan Administrator.

If the Plan is terminated, the rights of Plan Participants are limited to covered charges incurred before termination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Defined Terms. Defines those Plan terms that have a specific meaning.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Eligibility, Enrollment, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Qualified Medical Child Support Orders (QMCSOs). Explains the administrative process under state law wherein certain circumstances require health coverage for a participant's child.

Medical Benefits. Explains when the benefit applies and the types of charges covered.

Prescription Drug Benefits. Explains when the benefit applies and the types of charges covered.

Plan Exclusions and Limitations. Shows what charges are **not** covered or may have benefit limitations.

Ask-A-Nurse / Medical Management Services. Explains the methods used to curb unnecessary and excessive charges.

Claim Procedures. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment orders when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the **Plan's** rights to recover payment of charges when a Plan Participant has a claim against another person because of injuries sustained.

Responsibilities for Plan Administration. Outlines the duties of the employer plan sponsor, plan administrator and fiduciaries.

Special Provisions. Explains the **Plan's** structure and the Participants' rights under the Plan.

Important Notices of Participants Rights. Explains certain Participants rights under federal statutes such as COBRA, HIPAA and Medicare Part D.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized. Although these are some of the most commonly used terms in this document, this isn't a comprehensive list of all the important terms used in the Plan.

Subject to Plan exclusions and limitations, the **Allowable Amount** for **Network Providers** means the lesser of the billed charge amount, the contracted allowable amount, or the charge the Plan Administrator deems Reasonable and Necessary for the Plan.

The allowable amount for negotiated Providers is set forth in a separate agreement between the Plan and Provider.

Subject to Plan exclusions and limitations, the **Allowable Amount** for non-negotiated **Non-Network Providers** will be as follows:

Non-Network Provider	Allowable Charges
Procedures, services or supplies provided by non-network physicians, facilities, and suppliers	The lesser of 125% of the applicable CMS (Centers for Medicare & Medicaid Services) billing methodology (i.e. RBRVS, DRG, etc.) or the billed charge amount.
Procedures, services or supplies provided by a non-network radiologist, emergency room physician, pathologist, or for anesthesia services in a network facility	The lesser of 200% of the Resource Based Relative Value Scale (RBRVS) schedule as used by CMS (Centers for Medicare & Medicaid Services) or the billed charge amount.
Where codes have not been established by CMS, or claims cannot otherwise be repriced according to Medicare, the following will be the Allowable Amount for non-negotiated Non-Network charges:	
Inpatient Facility Medical/Surgical Room & Board	The lesser of the billed charge amount or $2,000 per diem (all inclusive).
Inpatient Facility ICU/CCU Room & Board	The lesser of the billed charge amount or $2,500 per diem (all inclusive).
Inpatient Mental Health/Substance Abuse	The lesser of the billed charge amount or $850 per diem (all inclusive).
Medical Device/Implant Charges *No amount will be paid by the Plan for medical devices/implants where codes have not been established by CMS until the specific medical device/implant invoice is submitted to the Plan by the hospital or other provider showing evidence of the actual net cost of the medical devices/implants paid by the hospital or other provider.*	The lesser of the billed charge amount or an amount equal to the actual net cost of the medical devices/implants paid by the provider plus 50% above said cost.
Inpatient Rehabilitation	The lesser of the billed charge amount or $1,750 per diem (all inclusive).
Skilled Nursing Facility	The lesser of the billed charge amount or $700 per diem (all inclusive).
All Other Non-Network Providers	30% of the billed charge amount.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Approved Leave of Absence means any absence by an Employee who is on a family and/or medical leave of absence or any other leave approved by the Employer under its usual policies. An approved leave of absence will run concurrently with leave under the Family Medical Leave Act unless specified in writing from the Employer that it will be treated differently.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse mid-wife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

Chiropractic Care/Spinal Manipulation means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Claims Administrator means Entrust, Inc.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance means a Covered Person's share of the cost of covered services and supplies, not counting the Deductible or co-payments. Coinsurance is usually expressed as a percentage of the allowable amount. For example, if the Coinsurance amount is "80/20" that means that the primary carrier pays 80% and the Plan Participant pays 20% of the allowable amount for the eligible charges.

Complications of Pregnancy is a condition or conditions with a diagnosis distinct from pregnancy but which may be caused by or adversely affected by pregnancy. Complications include but are not limited to:

(1) Nephritis, neophrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity; and

(2) Cesarean section, termination of ectopic pregnancy and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Convenience Care Clinic means the healthcare clinics located in retail stores, supermarkets and pharmacies that treat routine family illness on a limited basis and provide certain preventative healthcare services, such as flu shots.

Co-Payment is a fixed amount paid by the plan participant for covered services at the time they are rendered or for covered prescription medications.

Cosmetic Dentistry means unnecessary dental surgical procedures, usually but not limited to, plastic surgery directed toward enhancing dental attractiveness.

Cosmetic Surgery means medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurement.

Covered Person is an Employee or Dependent who is covered under the Plan.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication, which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Services means, with respect to an Emergency Medical Condition, treatment or services for an Injury or Illness that is of serious, life-threatening nature, developing suddenly and unexpectedly, and demanding immediate treatment that is within the capability of the emergency department of a Hospital or freestanding Emergency Room to evaluate such Emergency Medical Condition and to stabilize the patient.

Emergency Medical Condition means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions placing the health of the individual (or unborn child) in serious jeopardy.

Employee means a person who is a Full-Time Employee of the Employer, regularly scheduled to work for the Employer in an Employee-Employer relationship.

Employer is Braidwood Management, Inc.

End Stage Renal Disease (ESRD) means permanent kidney failure, requiring dialysis and/or an anticipated kidney transplant, entitling the Plan Participant or covered Dependent to Medicare coverage as established by the Balanced Budget Act of 1997.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The Plan Administrator will be guided by the following principles:

(1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) If the drug, device, treatment, or any combination thereof, is not FDA approved, whether it meets the National Comprehensive Cancer Network Guidelines for treatment; or

(3) If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(4) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(5) If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s)

of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Fiduciary means any person who exercises discretionary authority or control over managing the plan or managing or disposing of the plan's assets, or has any authority or responsibility to do so, or has any discretionary authority or responsibility for administering the plan. (See Plan Fiduciary)

FMLA means the Family and Medical Leave Act of 1993, as amended.

Foster Child means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee's; the child depends on the covered Employee for primary support; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Full-Time Employee means an Employee who normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.

Full-Time Employment means working at least 30 hours per week and being on the regular payroll of the Employer for that work.

Generic Drug means a Prescription Drug, which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any generic pharmaceutical, which is approved by the Food and Drug Administration ("FDA") and is dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic. However, a Prescription Drug will not be considered as generic unless it has been categorized by the FDA as generic for more than one year.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory test that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Home Health Care Agency is an organization that meets all of these test: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the home health care is in place of Hospital confinement; and it must specify the type and extent of home health care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two (2) unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hours-a-day nursing services by or under the supervision of registered nurses(R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "**Hospital**" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a condition, sickness or disease not resulting from trauma.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit". It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee is a Plan Participant who enrolls under the Plan other than during a Special Enrollment Period or during the initial 31-day period in which the Plan Participant first became eligible to enroll under the Plan.

Legal Guardian is a person recognized by a court of law with the duty of taking care of and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Plan Participant.

Medical Care Facility means a Hospital or other facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient. The fact that a physician may prescribe, order, recommend or approve of a service or supply does not, by itself, make it **Medically Necessary** or make the charge an allowable expense, even though it is not specifically listed as an exclusion.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Network means the Preferred Provider Organization (PPO) network of providers offering discounted fees for services and supplies to Covered Persons under the primary carrier plan.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Occupational Therapy is treatment of a physically disabled Plan Participant by means of constructive activities designed and adapted to promote the restoration of the person's ability to accomplish satisfactorily the ordinary tasks of daily living and those required by the person's particular occupation.

Open Enrollment Period will occur during the 30 days before and 15 days after the end of the current Plan year.

Outpatient Care is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or x-ray facility, an Ambulatory Surgical Center, or the patient's home.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a Pharmacist licensed under the laws of the state where he or she practices**.**

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Licensed Professional Surgical Assistant, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and/or certified and regulated by a state or federal agency and is acting within the scope of his or her license and/or certification.

Plan means the Braidwood Management Employee Benefit Plan Trust, which is a benefits plan for employees of the Employer.

Plan Administrator is an individual or group of individuals usually named in the plan document responsible for plan duties.

Plan Fiduciary means any person who exercises discretionary authority or control over managing the plan or managing or disposing of the plan's assets, or has any authority or responsibility to do so, or has any discretionary authority or responsibility for administering the plan. (See Fiduciary)

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Sponsor means Braidwood Management, Inc.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be **Medically Necessary** in the treatment of a Sickness or Injury.

Reasonable and Necessary Fees (R&N) means services and supplies which are medically necessary for the care and treatment of illness or injury, but only to the extent that such fees are reasonable. Determination that a fee is reasonable will be made by the Plan Administrator, taking into consideration:

- The fee which the provider charges the patients for the service or supply;
- Unusual circumstances or complications requiring additional time, skill and experience in connection with the particular service or supply; and/or
- The Allowable Amount as defined by the Plan.

Rehabilitation Facility is a facility licensed under state laws to provide skilled nursing care and intensive rehabilitative services. Rehabilitation Facilities are free standing rehabilitation hospitals and rehabilitation units in acute care hospitals. They provide an intensive rehabilitation program and patients who are admitted must be able to tolerate three hours of intense rehabilitation services per day.

Sickness is a person's illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
(2) Its services are provided for compensation and under the full-time supervision of a Physician.
(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
(4) It maintains a complete medical record on each patient.
(5) It has an effective utilization review plan.
(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
(7) It is approved and licensed by Medicare.

The term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home or any other similar nomenclature.

Specialty Drug is a Prescription Drug that is used to treat complex, chronic, or rare conditions. Factors considered in determining whether a drug is a specialty drug under this Plan include: a) if the drug requires patient monitoring or counseling to insure patient compliance; b) the drug requires special handling, distribution, monitoring, or administration; c) the cost is greater than the monthly specialty tier standard as defined by Medicare; d) and whether the drug is deemed a specialty drug by the plan's pharmacy benefit administrator, Southern Scripts.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulations or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that result in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Surgical Procedure (or Surgery) is any of the following:

- the incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of wounds;
- the manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of a cast or traction;
- the removal by endoscopic means of a stone or other foreign object from any part of the body, or the diagnostic examination by endoscopic means of any part of the body;
- arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
- obstetrical delivery and dilation and curettage;
- biopsy.

Temporomandibular Joint (TMJ) Syndrome is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

USERRA means the Uniformed Services Employment and Reemployment Rights Act.

Eligibility Defined Terms

Break in Service means a period of at least 13 consecutive Weeks during which the Employee has no Hours of Service, as defined herein. A Break in Service may also include any period for which the Employee has no Hours of Service that is at least four (4) consecutive Weeks in duration and longer than the prior period of employment (determined after applying the Special Unpaid Leaves of Absence procedures).

Employee means an individual classified by the Employer as a common law employee of the Employer, determined in accordance with rules and regulations issued by the Internal Revenue Service. Such term shall not include individuals classified by an Employer as independent contractors (including any person who later becomes reclassified as an employee by the Internal Revenue Service or a court of competent jurisdiction). For purposes of this subsection (e), any individual who pays or agrees to pay self-employment tax in lieu of withholding shall be deemed to be an independent contractor.

Hours of Service means each hour for which the Employee is paid or entitled to payment for performance of services for the Employer AND any hour for which the employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following, consistent with 29 C.F.R. 2530.200b-2(a)(i):

- Vacation
- Holiday
- Illness or incapacity
- Layoff
- Jury duty
- Military duty or leave of absence

Special Unpaid Leave of Absence means any of the following types of unpaid leaves of absence that do not constitute a Break in Service: (i) Leave protected by the Family and Medical Leave Act, (ii) leave protected by the Uniformed Services Employment and Reemployment Rights Act or (iii) Jury Duty (as reasonably defined by the Employer)

SCHEDULE OF BENEFITS
PLAN B
HIGH DEDUCTIBLE HEALTH PLAN

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
CALENDAR YEAR DEDUCTIBLE Individual Coverage	$2,000	
CALENDAR YEAR DEDUCTIBLE Family (*Embedded) Coverage	$4,000	
Note: Deductibles for Network and Non-Network Providers are combined		
*Embedded means that the single Deductible is embedded in the family Deductible. If a Covered Person has family coverage, no one individual will have to meet more than the single Deductible before benefits are paid for that individual. Once the family Deductible is met, no further Deductible will be taken for any family member.		
COINSURANCE	80%	60% ***Unless otherwise noted***
MAXIMUM OUT OF POCKET AMOUNT Includes Deductibles, Co-pays, and Coinsurance **Individual** **Family**	$4,000 $8,000	
Note: The Maximum Out-of-Pocket Expense for Network and Non-Network Providers Is Combined.		
Important Note: The Maximum Out-of-Pocket Expense does not include amounts that may be "Balance Billed" by providers due to charges that exceed the Plan's Defined Allowable Reimbursement Schedule.		
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
LIFETIME MAXIMUM AMOUNT *All Medical Benefits*	Unlimited	
Note: For Medically Necessary Services rendered by a Network or Non-Network Provider, the benefits of this Plan will be provided after the deductible has been met until the out-of-pocket amounts are reached each Calendar Year. Thereafter, this Plan will provide benefits at 100% of the Allowable charge for the remainder of the Calendar Year for all covered medical expenses, unless otherwise specified. Any balances of charges not covered by this Plan will be your responsibility to pay.		
PRE-NEGOTIATED/CASH PRICE OPTION If a Plan Participant's provider agrees to a pre-negotiated/cash price of not more than the Plan's Allowable Amount, then the Plan will reimburse the Plan Participant or the provider up to the Plan's Medicare Allowable Amount, not to exceed the amount paid for services. The Plan will reimburse the Plan Participant or provider once a claim and proof of payment are submitted to the Plan. Reimbursement as described in this paragraph is applicable to scheduled inpatient and outpatient procedures and will only occur in the event that the claim is a payable claim under the terms of this Plan Document & Summary Plan Description.		
COVERED SERVICES	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Subject to Plan exclusions and limitations, the Allowable Amount for Network Providers will be the contracted allowable amount; and, the Allowable Amount for Non-Network Providers is based on a limited fee schedule..		
PREVENTIVE CARE (includes screenings, counseling, immunizations, other preventive care services) *For additional information, see the Medical Benefits section of the Plan* Coverage under your health plan will not include coverage of abortifacient contraceptives services.	Covered at 100%	

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Subject to Plan exclusions and limitations, the Allowable Amount for Network Providers will be the contracted allowable amount; and, the Allowable Amount for Non-Network Providers is based on a limited fee schedule.		
PHYSICIAN'S OFFICE VISIT Includes all related services performed plus allergy testing and treatment, x-rays, laboratory tests, and i*n-office surgery*.	Covered at 80% after deductible	
CONVENIENCE CARE CLINICS Healthcare clinics located in retail stores, supermarkets and pharmacies that treat routine family illness on a limited basis.	Covered at 80% after deductible	Covered at 60% after deductible
URGENT CARE FACILITY & PHYSICIAN SERVICES *Charges must be on the same bill as the visit charges and incurred at the same time as the visit*	Covered at 80% after deductible	Covered at 60% after deductible
OUTPATIENT DIAGNOSTIC TESTING, LABORATORY, AND/OR RADIOLOGY (Hospital and Freestanding Facility) *MRI, CT and PET scans at a One Call Medical Facility will be considered at the Network level of benefits*	Covered at 80% after deductible	Covered at 60% after deductible
EMERGENCY ROOM Emergency Services/Accidental Injury *No Prior Authorization required for Emergency Services.* **Hospital Services** **Physician Services**	 Covered at 100% Covered at 80% after deductible	
Note: *Non-Network Emergency Services rendered for an Emergency Medical Condition will be payable at the Network level of benefits at the Non-Network Allowable Amount.*		
PRIOR AUTHORIZATION/UTILIZATION REVIEW **Inpatient Hospital confinement must be Prior Authorized.** **Prior Authorization is not required for Inpatient maternity confinements within the minimum stay requirements. Failure to Prior Authorize treatment will result in a penalty of $250.** **Proper Authorization must be obtained in a timely manner.** **It is ultimately the responsibility of the Plan Participant to make sure that the provider complies with the Prior Authorization/Utilization Review requirements.** **Please see the Medical Management section of the SPD for details.**		
HOSPITAL SERVICE – Inpatient/Outpatient Daily Room and Board limited to the charges up to the semi-private room rate, unless the hospital only has private rooms available, then it will be the private room rate. Intensive Care Unit limited to the Hospital's ICU charge.	Covered at 80% after deductible	Covered at 60% after deductible

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Subject to Plan exclusions and limitations, the Allowable Amount for Network Providers will be the contracted allowable amount; and, the Allowable Amount for Non-Network Providers is based on a limited fee schedule.		
DIRECT AGREEMENT FACILITIES – FACILITY CHARGES ONLY	Covered at 100%	
SKILLED NURSING FACILITY - **Inpatient Services** Note: Limited to 30 days per Calendar Year unless otherwise stated in a separate provider agreement. Subject to Prior authorization and/or case management.	Covered at 80% after deductible	Covered at 60% after deductible
BIRTHING CENTER	Covered at 80% after deductible	
HOSPITAL CONFINEMENT FOR REHABILITATION Subject to Prior authorization and/or case management.	Covered at 80% after deductible	Covered at 60% after deductible
Covered services provided by a non-network radiologist, anesthesiologist, pathologist or other physician over whom the Plan Participant has no control in selecting while receiving care (Inpatient/Outpatient) from a Network Hospital will be payable at the Network level of benefits.		
SURGERY- PHYSICIAN CHARGES • Inpatient Hospital • Outpatient Hospital • Outpatient Surgical Facility • Office/Urgent Care Facility Includes surgeon, assistant surgeon anesthesiologist services	Covered at 80% after deductible	Covered at 60% after deductible
HOME HEALTH CARE Limited to 100 visits per Calendar Year	Covered at 80% after deductible	Covered at 60% after deductible
HOSPICE CARE	Covered at 80% after deductible	Covered at 60% after deductible
DURABLE MEDICAL EQUIPMENT	Covered at 80% after deductible	Covered at 60% after deductible
OUTPATIENT PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY Limited to 20 visits per category of service per Calendar Year	Covered at 80% after deductible	Covered at 60% after deductible
PROSTHETICS	Covered at 80% after deductible	Covered at 60% after deductible
OUTPATIENT RADIATION/CHEMO/IV THERAPY (Hospital, Freestanding Facility or Physician's Office)	Covered at 80% after deductible	Covered at 60% after deductible

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Subject to Plan exclusions and limitations, the Allowable Amount for Network Providers will be the contracted allowable amount; and, the Allowable Amount for Non-Network Providers is based on a limited fee schedule.		
MATERNITY CARE *Employee and Spouse only*	Benefits are the same as those stated under Covered Services category	
CHIROPRACTIC/ SPINAL MANIPULATION SERVICES $1,500 Maximum Benefit per Calendar Year	Covered at 80% after deductible	Covered at 60% after deductible
BEREAVEMENT COUNSELING Limited to 15 visits per Calendar Year	Covered at 50% after deductible	
AMBULANCE SERVICES	Covered at 80% after deductible	
MENTAL HEALTH/SUBSTANCE ABUSE	Not Covered	
ALL OTHER COVERED MEDICAL EXPENSES	Covered at 80% after deductible	Covered at 60% after deductible

PRESCRIPTION DRUGS

	30 Day Supply	**90 Day/Mail Order**
GENERIC	Covered at 80% after deductible	
BRAND NAME	Covered at 80% after deductible	
SPECIALTY DRUGS	Covered at 80% after deductible	Not Covered
PREVENTIVE DRUGS	$0 Co-pay	
***No co-pay for generic preventive drugs and contraceptives only unless a generic drug is deemed medically inappropriate by the prescribing physician.**		
EXCLUSIONS: "ME-TOO" DRUGS – Chemically similar drugs that share the same mechanism of action to a less expensive existing approved chemical entity (i.e. Prilosec & Nexium). **NON-ESSENTIAL –** Medications in a dosage form that increased the cost for treatment, when other less expensive dosage forms are available (i.e. topical patches & creams).		
Coverage under your health plan will not include coverage of abortifacient contraceptives services.		

ELIGIBILITY REQUIREMENTS

Eligibility Requirements For Employee Coverage

A person is eligible for Employee coverage once he or she:

(1) is a Full-Time Employee of the Employer; and
(2) completes the employment waiting period. A "waiting period" is that time between the first day of employment and the first day of coverage under the Plan. The waiting period under the Plan is completed on the first (1st) of the month that coincides with one (1) month of Full-Time Employment. However, if one (1) month of Full-Time Employment does not coincide with the first (1st) of the month, then the waiting period will be completed on the first (1st) of the following month.

For purposes of completing the waiting period, an Employee who is on an Approved Leave of Absence will still be treated as a Full-Time Employee. Eligibility for coverage under the Plan shall continue during an approved Leave of Absence, for a period not to exceed the actual period of Leave, just as though the covered Employee was still a Full-Time Employee of the Employer. ***This provision does not provide a Participant with a Leave of Absence; rather, it is merely an attempt to coordinate with the Employer's policies.***

Eligible Classes of Employees
Once an Employee meets the eligibility requirements and becomes eligible for Employee coverage, the Employee remains in the eligible classes of Employees as long as the Employee is a Full-Time Employee.

Further, an Employee is considered a Full-Time Employee on each day of a regular paid vacation and on each regular non-working day if the Employee was a Full-Time Employee on the last preceding regular work day.

Impact of Breaks In Service
Any Employee who resumes Hours of Service following a Break in Service will be treated as a new hire. For example, if you are out on leave for 8 weeks, you will not be considered a New Hire and will not have to satisfy any applicable waiting period. If, however, the Employee experiences a period without any Hours of Service, and resumes Hours of Service without experiencing a Break in Service, the Employee will be treated as a continuous employee. A continuous employee resuming Hours of Service after a period with no Hours of Service that does not constitute a Break in Service will be eligible for coverage under the Plan upon return if they were enrolled in coverage prior to the start of the period with no Hours of Service. Such coverage will be effective on the first day of the month that coincides with or follows the date you resume Hours of Service.

Eligible Classes of Dependents
Dependent is any one of the following persons:

(1) A covered Employee's Spouse and children from birth to the limiting age of 26 years. When a Dependent child reaches the limiting age, coverage will end on the child's birthday. The Plan Administrator will require documentation to determine eligibility status of Dependent child.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the United States.

The term "children" shall include natural children, adopted children or children placed with a covered Employee in anticipation of adoption. Stepchildren or Foster Children shall also be included if the Employee so chooses.

If a covered Employee is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents provided such child (or children) is primarily dependent on the Employee.

Notwithstanding any Plan provision to the contrary, the Plan will provide benefits to dependent children placed with Plan Participants or beneficiaries for adoption as required by ERISA Section 609I and as required by part 7 of ERISA. The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption to the child. The federal Omnibus Budget Reconciliation Act of 1993, as well as the Child Support Performance and Incentive Act, requires coverage of these pre-adoptive children. The child must be available for adoption and the legal process must have been commenced.

As required by the federal Child Support Performance and Incentive Act (CSPIA), any child of a Plan Participant who is an alternate recipient under a qualified medical child support order (QMCSO) shall be considered as having a right to Dependent coverage under this Plan. See the Qualified Medical Child Support Order (QMCSO) section for more details.

The Plan Administrator may require documentation-proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(1) A covered Dependent child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, primarily dependent upon the covered Employee for support and maintenance, unmarried and covered under the

Plan when reaching the limiting age. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for all amounts applied to maximums.

If both husband and wife are Employees, their children will be covered as Dependents of the husband or wife, but not of both.

Eligibility Requirements For Dependent Coverage.
A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan. All dependents must be enrolled in the same plan.

ENROLLMENT

Enrollment Requirements.
To obtain coverage, an Employee must enroll for coverage by filling out and signing an enrollment application. To obtain Dependent Coverage, the covered Employee must enroll such Dependents, including newborn children.

Newly Acquired Dependents and Dependents Becoming Eligible Other Than During Group Enrollment.
A newly acquired Eligible Dependent (other than a newborn child and a newly adopted child) shall be covered on the first day of the month following the day on which he/she first becomes eligible.

Newborn Children and Newly Adopted Children of Covered Employee
In order to be covered timely, the covered Employee must submit written notice to the Plan Sponsor within thirty-one (31) days of the birth, adoption or placement for adoption. Otherwise,

the child will not be allowed to enter the Plan until the next Open Enrollment Period or if he/she has a Special Enrollment Provision.

Timely and Late Enrollment

Timely Enrollment – The enrollment will be "timely" if the completed form is received by the Employer no later than thirty-one (31) days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

Late Enrollment – An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late enrollees will not be allowed to enroll under the Plan unless they enroll during an Open Enrollment Period or during a Special Enrollment Period. However, if an eligible Employee or eligible Dependent is able to enroll "late" due to a Special Enrollment Period, then the eligible Employee or Dependent, by law, cannot be considered as a "late enrollee" and thus must be considered to have "timely enrolled".

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The enrollment date for a Late Enrollee is the first day of coverage. Thus, the time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no waiting period as long as coverage has been continuous.

SPECIAL ENROLLMENT PERIOD

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the date of the first day of coverage is not treated as a waiting period.

(1) **Individual losing other coverage.** An Employee who is eligible, but not enrolled in this Plan, may enroll if any of the following conditions are met:

(a) The Employee (or Dependent) was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual. If required by the Employer, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment. The Employee requests enrollment in this Plan not later than thirty-one (31) days after the loss of coverage.

(b) The coverage of the Employee (or Dependent) who has lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or the other coverage no longer offers benefits to the class of employees under which the Employee (or Dependent) was covered) or employer contributions toward the coverage were terminated, or the Employee (or Dependent) incurs a claim under the other coverage that would meet or exceed the lifetime limit on all benefits for that other coverage.The Employee requests enrollment in this Plan not later than thirty-one (31) days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above.

(2) **Dependent beneficiaries.** A Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee if the following conditions are met:

(a) The Employee is a participant under this Plan (or has met the waiting period applicable to becoming a participant under this Plan) and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period, and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption, and;

(c) The Employee requests enrollment for the dependent in this Plan not later than thirty-one (31) days after the dependent becomes an eligible dependent.

(3) **Loss of coverage under Medicaid or a state child health plan**. An Employee or a Dependent may enroll if the following conditions are met:

(a) An Employee or a Dependent loses coverage under Medicaid or a state child health plan.

(b) The Employee requests enrollment of the Employee and any Dependents in the Plan not later than sixty (60) days after the date the coverage ends under Medicaid or the state child health plan.

(4) **Gaining eligibility for premium assistance under Medicaid or a state child health plan**. An employee or a Dependent may enroll if the following conditions are met**:**

(a) An Employee or a Dependent becomes eligible for financial assistance from Medicaid or a state child health plan.

(b) The Employee or a Dependent requests enrollment of the Employee and any Dependents no later than sixty (60) days after the date that Medicaid or the

state child health plan determines that the Employee or any Dependents are eligible for such financial assistance.

If the Employee (or Dependent) lost the other coverage as a result of the individual's failure to pay premiums or for cause (such as making a fraudulent claim), that individual does not have a special enrollment right.

In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

Any eligible Employee or eligible Dependent who enrolls during a Special Enrollment will be treated as if he or she had timely enrolled.

OPEN ENROLLMENT

The annual Open Enrollment will occur during a period of time designated by the Plan Administrator.

During the annual open enrollment period, eligible Employees and their eligible Dependents not previously enrolled under the Plan will be able to enroll for coverage. Also, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverage(s) are right for them.

Benefit choices made during the open enrollment period will become effective on the Plan's Anniversary Date and remain in effective unless the Employee or Dependent qualifies to enroll during a Special Enrollment Period (please see the "SPECIAL ENROLLMENT PERIODS" subsection under the "ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS" section). Coverage Waiting Periods are waived during open enrollment for covered Employees and covered Dependents changing from one plan to another plan or from one Preferred Provider Organization (PPO) Network to another PPO.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverage(s).

Employees will receive detailed information regarding open enrollment from their Employer.

EFFECTIVE DATE

Effective Date of Employee Coverage.
An Employee will be covered under this Plan as of the date that the Employee satisfies all of the following:

(1) The Eligibility Requirements; and
(2) The Enrollment Requirements of the Plan.

Effective Date of Dependent Coverage.
A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

The coverage of the Dependents enrolled in the Special Enrollment Period will become effective:

(1) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
(2) in the case of a Dependent's birth, as of the date of birth; or
(3) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

TERMINATION OF COVERAGE

When Employee Coverage Terminates.
Employee coverage will terminate on the earliest of the following dates:

(1) The date the Plan is terminated or the date of the month of Employee termination of employment.
(2) The date of the month in which the covered Employee ceases to be in the Eligible Classes of Employees. This includes death or termination of employment of the covered Employee. (See the COBRA Continuation Option.)
(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Option.

Continuation During Periods of Employer-Certified Disability Leave or Leave of Absence.
A person shall remain covered for a limited time if full-time work ceases due to disability or leave of absence. The 90 day period will run concurrently with FMLA leave, as applicable. This continuance will end upon the expiration ninety (90) days from the date on which the person last worked as a Full-Time Employee.

Unless otherwise required by law, while continued, coverage will be that which was in force on the last day worked as a Full-Time Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee.
A terminated Employee, who is rehired more than ninety-one (91) days after the prior date of termination, will be treated as a new hire and be required to satisfy all Eligibility and enrollment requirements, with the exception of an Employee returning to work directly from COBRA coverage. This Employee does not have to satisfy the employment-waiting period.

Vacation, Sick, and Paid Time Off. A person who is using accrued days for vacation, sick, or paid time off shall be considered actively at work and remain a Plan Participant during such time. Vacation, sick, and paid time off days shall be in addition to and not be included in any leave taken as Employer-Certified Disability Leave or Leave of Absence or Continuation during Family and Medical Leave regardless of whether vacation, sick, or paid time off is taken before or after such leave.

Employees on Military Leave.
An Employee who is absent from work for more than thirty (30) days in order to fulfill a period of duty in the Uniformed Services of the United States has a Qualifying Event as of the first day of the Employee's absence for such duty, and thus is eligible for rights under USERRA. The Plan Sponsor shall furnish to the Employee a notice of the right to elect continuation coverage under USERRA and shall afford the Employee the opportunity to elect such coverage in accordance with USERRA. If the Employee elects coverage, the right to that coverage ends on the earlier of: A) on the day after the deadline for the Employee to apply for reemployment with or return to active employment with the Employer or B) twenty four (24) months beginning on the date of the employee's absence from employment with the Employer.

However, during the first thirty (30) days that the Employee is absent in order to fulfill a period of duty in the Uniformed Services of the United States, the Employee must be treated the same as any other employee. This means the higher USERRA premium cannot be collected from the Employee for the first thirty (30) days. After the Employee has been absent for more than thirty (30) days, the Employee will receive immediate USERRA coverage upon payment of the entire cost of coverage plus a reasonable administration fee. Further, the Employee will have no

preexisting condition exclusions applied by the Plan upon return from service. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

In many instances, an Employee eligible for continuation of coverage under USERRA will also be eligible for continuation of coverage under COBRA. To the extent allowed under the law, the continuation of coverage periods under COBRA and USERRA will run concurrently under the plan.

Plan exclusions and waiting periods may be imposed for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

When Dependent Coverage Terminates.
A Dependent's coverage will terminate on the earliest of the following dates:

(1) The date the Plan is terminated.
(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Option.)
(3) The date Dependent coverage is terminated under the Plan.
(4) On the last day of the month that he or she ceases to be a Dependent as defined by the Plan. (See the COBRA Continuation Option.)
(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Option.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

Pursuant to Section 609(a) of the Employee Retirement Income Security Act of 1974 (ERISA), Plan Sponsors are required to develop administrative procedures for handling QMCSOs. This Section sets forth the procedures to be followed by The Employee Health Benefit Plan as sponsored by the Employer shown in Appendix A**.**

A QMCSO is a court judgment, decree, or order, or a state administrative order that has the force and effect of law that is typically issued as part of a divorce or as part of a state child support order proceeding, and that requires health plan coverage for an "alternate recipient," the child of a participant. Federal law requires a group health plan to pay benefits in accordance with such an order, if it is "qualified." A QMCSO may apply to the self-funded health plan, the self-funded dental plan (if any), and the health care spending account (if any). In general, an alternate recipient child under a QMCSO is to be treated like any other child of a Plan participant.

These orders (QMCSO) are usually drafted by attorneys for the divorcing couple or by the state child support agency. There is no standard format required; however, each order must contain certain information specified by Section 609(a).

In some cases, orders will be based on state laws enacted in response to Section 1908 of the Social Security Act, which requires states to enact certain child support laws, or face the loss of federal Medicaid funds. These state laws are designed to help state governments obtain private-sector coverage for children who would otherwise be eligible for state Medicaid coverage. Both the state and the non-employee parent can obtain a court order to force coverage under the plan, even if the employee is not interested in obtaining plan coverage for the child.

Plan's Rights and Responsibilities:
All actions related to QMCSOs must be made in conformance with these procedures and must be performed on a timely basis.

The Plan is not required to provide coverage in accordance with a child support or other court orders, which are not "qualified" in accordance with Section 609(a) of ERISA. The Plan Administrator has the ultimate authority to determine whether or not the order meets all of the requirements of Section 609(a). If the order does not meet all of the qualification requirements, the plan need not and will not provide any benefits to the alternate recipient child, unless the parties later correct the deficiencies.

Plan Procedures for handling QMCSOs

(1) Upon receipt of an order, the Plan Administrator must:
  (a) Promptly send written notice of the receipt of the order to the participant and all alternate recipient children named in the order.
  (b) Review the order to determine if it meets the legal requirements of QMCSO.
(2) Within a reasonable time of the receipt of the order, the Plan Administrator must notify the participant and alternate recipient children that either:
  (a) The order is a valid QMCSO; or
  (b) The order is not a valid QMCSO (including an explanation of what provisions are defective or missing).
(3) Any disputes raised by the parties are to be referred to the Plan's legal counsel.
(4) If an order is found to be invalid, the parties may "cure" the deficiencies with a subsequent order. If an amended order is submitted, the evaluation process is reinitiated for the new order.

Administrative Guidelines:
An order will be considered "qualified" upon receipt and approval of the following:

(1) The name and last known mailing address of each alternate recipient. In some cases, a state agency will be named in place of the child.
(2) A "reasonable description" of the type of coverage or benefits provided by the Plan.

(3) The period of time to which the order applies.
(4) The identification of each plan to which the order applies.

The order cannot require the Plan to provide any benefits not currently being provided under the Plan, or to alter the Plan's eligibility requirements.

MEDICAL BENEFITS

Medical Benefits apply when covered medical charges are incurred by a Plan Participant for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

Selection of Your Health Care Provider.
The Plan offers a Preferred Provider Organization (PPO) network for certain services. This Plan has entered into an agreement with a PPO Network(s) that have agreements with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to reduce their fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Therefore, when a Plan Participant uses a Network Provider, that Plan Participant will receive a higher percentage reimbursement from the Plan than when a Non-Network Provider is used. It is the Plan Participant's choice as to which Provider to use.

When a Plan offers a PPO, you may see any provider you desire. However, your benefits may be reduced if you choose a Non-Network provider. (Network benefits will be paid for a Non-Network Provider if a Network Provider, **capable of providing the required medical services,** is not located within a 50-mile radius of the Covered Persons' residence.)

It is the responsibility of the Plan Participant to determine whether their provider of choice is currently in or out of the network used by their plan.

Please note: Network providers may change networks and the Network Directory or web site may not always reflect a providers' current status. Therefore, it is always advisable to call the PPO's Customer Service Department to verify the current status of the provider. The name, phone number and web site of your PPO Network, if applicable, is shown in the attached Appendix A. A list of Network Providers in your area is available by contacting the Employer Plan Sponsor, or a complete listing is available by accessing the web site listed in Appendix A.

Non-network providers are not required to accept the Plan's Allowable Amount as payment in full and may balance bill you for the difference between the Plan's non-network Allowable Amount and the provider's billed charges. You will be responsible for this balance bill amount, which may be considerable. You will also be responsible for charges for services, supplies and procedures limited or excluded under the Plan and any applicable deductibles, coinsurance amounts, and copayment amounts.

Deductible
Deductibles are dollar amounts that the Plan Participant must pay before the Plan pays.

Annual Deductible. An annual deductible is an amount of money that is paid once a Calendar Year per Plan Participant. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each January 1st, a new deductible amount is required.

Deductible Three-Month Carryover. Covered expenses incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next Calendar Year.

Copayment.
Co-payments are dollar amounts that the Plan Participant must pay before the Plan pays.

A co-payment is a smaller amount of money that is paid by the plan participant each time a specified service is used (*see Schedule of Benefits*). Typically, there may be co-payments on some services and other services will not have any co-payments.

Physician Office Visit Co-payment. The Physician Office Visit Co-payment applies to Covered Expenses for charges made by a Network Physician for services and supplies given in connection with an office visit. The amount of the Physician Office Visit Co-payment is shown in the Schedule of Benefits.

This Co-payment does not apply to prenatal and postnatal office visits to the Network OB/GYN who is primarily responsible for your maternity care.

Benefit Payment
Each Calendar Year, benefits will be paid for the covered charges of a Plan Participant. Payment will be made at the rate shown in the Schedule of Benefits.

Out-of-Pocket Expense
You must pay for a certain portion of the cost of covered expenses under the Plan, including deductibles, co-payments and the coinsurance percentage that is not paid by the Plan. This is called "out-of-pocket expense." The Maximum Out-of-Pocket amount is defined in the Schedule of Benefits and does not include any contribution you pay to participate in the plan, any amount balance billed by your providers, or the cost for any services not covered by the Plan.

COVERED MEDICAL EXPENSES

Covered charges are the Allowable Charges that are incurred for the following items of service and supply. These charges are subject to the "Benefit Limits" of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and

board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

If a hospital has only private rooms available or if a hospital is a private room only facility, the allowable is the hospital's private room rate.

Intensive Care and Progressive Care charges will be covered to the hospital's usual charge.

(2) **Hospital Confinement for Rehabilitation**
There must be a medical necessity for the confinement and it must begin within 14 days of a Hospital confinement of at least 3 days. Additionally, the patient must be able to participate in the therapy and there must be a potential for recovery. Prior Authorization is required and the confinement may be subject to case management.

(3) **Skilled Nursing Facility Care**
All Skilled Nursing Facility Care claims are subject to case management and to the following conditions:

(a) The patient is confined as a bed patient in the facility;
(b) the confinement starts within 14 days of a Hospital confinement of at least 3 days;
(c) the confinement is needed for further care of the condition that caused the Hospital confinement; and
(d) said confinement is deemed medically necessary and has been Authorized by the Plan.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services. This includes pharmacologic management for mental and nervous conditions.

(5) **Assistant Surgeon Services**
Network Providers :
Covered Expenses for services of an assistant surgeon (M.D.) are limited to 20% of the amount of Covered Expenses for the surgeon's charge for the surgical procedure(s) performed. If a Licensed Surgical Assistant or other provider is eligible under the definition of Physician in this Document, those services will be limited to 15% of the amount of Covered Expenses for the surgeon's charge for the surgical procedure(s) performed.

Non-Network Providers
Services from Non-Network providers will be paid according to the Non-Network Allowable Amount.

(6) **Multiple surgical procedures**

Covered Expenses for multiple surgical procedures performed at one operative session are limited as follows:

(a) Covered Expenses for the second procedure are limited to 50% of the Covered Expenses for the secondary procedure.
(b) Covered Expenses for any subsequent procedure are limited to 50% of the Covered Expenses for the subsequent procedure

Note: Multiple surgical reductions of Covered Expenses will not apply to surgical procedures that are identified as add-on procedures by the AMA. Add-on codes describe additional intra-service work associated with the primary service/procedure.

(7) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:

(a) Inpatient Nursing Care. Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) Outpatient Nursing Care. Charges are covered only when care is **Medically Necessary** and not Custodial in nature.

(8) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or 4 hours of home health aide services.

(9) **Hospice/Home Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Plan Participant's condition as being terminal, determined that the person is not expected to live more than 6 months and placed the person under a Hospice Care Plan. Services and supplies for Hospice Care are subject to case management approval.

(10) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) Local **Medically Necessary** professional land or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided, but in any event, no more than 50 miles from the place of pickup, unless the Plan Administrator finds a longer trip was **Medically Necessary**.

(b) Anesthetic; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(c) Cardiac rehabilitation as deemed **Medically Necessary** provided services are rendered (a) under the supervision of a Physician; (b) initiated within 12 weeks after other treatment for the medical condition ends; and (c) in a Medical Care Facility as defined by this Plan.

(d) Radiation or chemotherapy and treatment with radioactive substances. The materials and services of technicians are included.

(e) Initial contact lenses or glasses required following cataract surgery.

(f) Laboratory studies.

(g) The initial purchase, fitting, repair and replacement of orthotic appliances such as braces, splints or other appliances, which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(h) The initial purchase, fitting, repair and replacement of fitted prosthetic devices, which replace body parts.

(i) Sterilization procedures.

(j) Surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations.

(k) Diagnostic x-rays.

(l) PET Scans, but only if Medically Necessary. PET Scans are limited to two (2) per Calendar Year, unless approved under an Alternative Care Program (See Alternative Care Program below).

Emergency Services
Emergency Services means, with respect to an Emergency Medical Condition, treatment or services for an Injury or Illness that is of serious, life-threatening nature, developing suddenly and unexpectedly, and demanding immediate treatment that is within the capability of the emergency department of a Hospital to evaluate such Emergency Medical Condition and to stabilize the patient.

Emergency Medical Condition means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions placing the health of the individual (or unborn child) in serious jeopardy.

For Medically Necessary Emergency Services rendered by a Network or a Non-Network provider, this Plan will provide benefits as specified in the Schedule of Benefits. Any balance of charges not covered by this Plan will be your responsibility to pay.

Treatment of Diabetes
Charges will be determined on the same basis as any other illness for those Medically Necessary items for Diabetes Equipment and Diabetes Supplies (for which a Physician has written an order) and Diabetic Management Services/Diabetes Self-Management Training. Such items shall include but not be limited to the following:

Diabetes Equipment
- Blood glucose monitors (including noninvasive glucose monitors, continuous monitors, and monitors for the blind);
- Insulin pumps (both external and implantable) and associated equipment and/or supplies, which include but are not limited to:
  - Insulin infusion devices,
  - Batteries,
  - Skin preparation items,
  - Adhesive supplies,
  - Infusion sets,
  - Insulin cartridges,
  - Durable and disposable devices to assist in the injection of insulin, and
  - Other required disposable supplies; and
- Podiatric appliances, including up to two pairs of therapeutic footwear per Calendar Year, for the prevention and/or treatment of complications associated with diabetes.

Diabetic Supplies including, but not limited to:
- Test strips for blood glucose monitors,
- Visual reading and urine test strips and tablets for glucose, ketones, and protein,
- Lancets and lancet devices,
- Insulin and insulin analog preparations,
- Injection aids, including devices used to assist with insulin injection and needleless systems,

- Biohazard disposable containers,
- Insulin syringes,
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
- Glucagon emergency kits.

NOTE: *Insulin and insulin analog preparations, insulin syringes necessary for self-administration, prescriptive oral agents will be covered under the Prescription Drug Program. Injection Aids and Disposable Containers will be covered as a medical expense subject to deductible and co-insurance when submitted to the Plan for reimbursement.*

As new or improved treatment and monitoring equipment or supplies become available and are approved by the U.S. Food and Drug Administration (FDA), such equipment or supplies may be covered determined to be Medically Necessary and appropriate by the treating Physician who issues the written order for the supplies or equipment.

Services provided for the nutritional, educational, and psychosocial treatment of the Participant. Such Diabetic Management Services/Diabetes Self-Management Training, for which a Physician has written an order to the Participant or caretaker of the Participant, is limited to the following when rendered by or under the direction of a Physician.

Initial and follow-up instruction concerning;

1) The physical cause and process of diabetes;
2) Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
3) Prevention and treatment of special health problems for the diabetic patient;
4) Adjustment to lifestyle modifications; and
5) Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

Diabetes Self-Management Training for the Qualified Participant will include the development of an individualized management plan that is created for and in collaboration with the Qualified Participant (and/or his or her family) to understand the care and management of diabetes, including nutritional counseling and proper use of Diabetes Equipment and Diabetes Supplies.

A Qualified Participant means an individual eligible for coverage under this Plan who has been diagnosed with (a) insulin dependent or non-insulin dependent diabetes, also known as Type 1 Diabetes and Type 2 Diabetes, or (b) elevated blood glucose levels induced by pregnancy, also known as Gestational Diabetes (GDM).

Injury to or Care of Mouth, Teeth and Gums
Charges for injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under Medical Benefits only if that care is for the following oral surgical procedures:

(1) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
(2) Emergency repair due to Injury to sound natural teeth. This repair must be made within 12 months from the date of an accident.
(3) Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of mouth.
(4) Excision of benign bony growths of the jaw and hard palate.
(5) External incision and drainage of cellulites.
(6) Incision of sensory sinuses, salivary glands or ducts.
(7) Removal of impacted teeth.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

Medically Necessary - Services furnished by hospital during confinement in connection with dental treatment will be considered covered medical expenses.

Clinical Trials
Charges for Routine Patient Costs for items and services furnished to a Covered Person who is a Qualified Individual in connection with participation in an Approved Clinical Trial. The Plan will not deny such a Covered Person's participation in an Approved Clinical Trial or discriminate against such a Covered Person on the basis of his or her participation in an Approved Clinical Trial.

Plan Participants must notify Medical Helpline of any participation in an Approved Clinical Trial.

The following definitions apply for purposes of clinical trial coverage under the Plan:

1. The term "Approved Clinical Trial" means a phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition, as further described in Section 2709(d) of the Public Health Services Act.

2. The term "Qualified Individual" means a Covered Person who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or condition and where either the referring health care professional is a participating health care provider and has concluded that the individual's participation in the clinical trial would be appropriate based upon the individual meeting the trial protocol, or the individual provides medical and scientific information establishing that his or her participation in the clinical trial will be appropriate based upon the individual meeting the trial protocol.

3. The term "Routine Patient Costs" means items and services consistent with the Plan's typical coverage for a Covered Person who is not enrolled in a clinical trial.

Routine Patient Costs does not include the investigational item, device or service itself, items and services that are provided solely to satisfy data collection and analysis needs of the clinical trial and that are not used in the direct clinical management of the patient, or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

4. The term "life-threatening condition" means a disease or condition likely to result in death unless the disease or condition is interrupted.

Occupational Therapy
Subject to an approved plan of treatment, charges for occupational therapy are covered only if ordered by a Physician, results from an Injury or Sickness and improves a body function. The occupational therapy must be performed by a licensed occupational therapist or physician. Once covered, the charges will be payable as described in the Schedule of Benefits and limited as reflected in the Schedule of Benefits. However, any visits beyond the maximum amount of visits per illness or injury or beyond than the maximum amount of visits will not be covered unless found to be Medically Necessary. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

Physical Therapy
Subject to an approved plan of treatment, charges for physical therapy are covered only if ordered by a Physician, results from an Injury or Sickness and improves a body function. The physical therapy must be performed by a licensed physical therapist or physician. Once covered, the charges will be payable as described in the Schedule of Benefits and limited as reflected in the Schedule of Benefits. However, any visits beyond the maximum amount of visits per illness or injury or beyond than the maximum amount of visits will not be covered unless found to be Medically Necessary. Covered expenses do not include recreational programs, maintenance therapy or supplies used in physical therapy, with the exception of hot and cold packs.

Speech Therapy
Subject to an approved plan of treatment, charges for speech therapy are covered only if ordered by a Physician and follow either: (1) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy); (2) an Injury; or (3) a Sickness that is other than a learning or Mental Disorder. The speech therapy must be performed by a licensed speech therapist or physician. Once covered, the charges will be payable as described in the Schedule of Benefits and limited as reflected in the Schedule of Benefits. However, any visits beyond the maximum amount of visits per illness or injury or beyond than the maximum amount of visits will not be covered unless found to be Medically Necessary. The developmental speech problems of a child would not qualify for coverage.

Durable Medical Equipment
Charges for durable medical equipment will be payable as described in the Schedule of Benefits and may be subject to case management. Rental of durable medical or surgical equipment will be covered if deemed Medically Necessary and the charge for rental is not reasonably expected to exceed the purchase price. These items may be bought rather than rented, but only if agreed to in advance by the Plan Administrator.

Prosthetics/Orthotics
Charges for prosthetics/orthotics will be payable as described in the Schedule of Benefits and may be subject to case management.

Chiropractic Services/Spinal Manipulation
Chiropractic services/Spinal manipulation will be paid as shown in the Schedule of Benefits and may be subject to case management.

Medical Devices/Implants
Network Providers
Charges for medical devices/implants from network providers will be reimbursed at the PPO Allowable Amount.

Non-Network Providers
Total charges for medical devices/implants from non-network providers will be paid according to the Plan Allowable Amount.

Radiology Services
One Call Medical is a preferred provider organization (PPO) of over 2,900 radiology facilities in the United States that provide MRIs, CT scans, PET scans and other radiology and diagnostic services. Subject to plan limitations and exclusions, Covered Services provided at One Call Medical facilities are paid at the Network level of benefits. Use of the One Call Medical PPO network can create significant savings for the Plan and Plan Participants. To locate a One Call Medical PPO facility, call (888) 458-8746 or go to www.onecallmedical.com. *This benefit is available only if shown in your Schedule of Benefits.*

Transplants – Organs/Marrow/Tissues

1. Center of Excellence Transplant Benefit
The Plan includes a Centers of Excellence (COE) transplant benefit and offers transplant benefits to eligible Plan Participants. COE means a facility that has been designated by the Plan Administrator as a Center of Excellence. Coverage for transplant services rendered at a COE facility will be paid at 100% of eligible hospital, professional and organ/marrow charges according to contract terms negotiated by the Plan. Co-payments, deductibles and other Plan Participant responsibilities still apply. **Other than as provided in paragraph 3 below, the Plan does not cover organ/marrow/tissue transplants outside of a COE facility or non-emergency transplants that have not received prior-authorization.**

2. ***Covered Transplants***
Transplant services are covered at 100% benefit level only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestinal which includes small bowel, liver or multivisceral.

3. ***Emergency Transplant Care at Non-COE Facilities***

Coverage for unplanned and unscheduled emergency transplantation ("Emergency Transplant") is a benefit included in the Plan, to be paid according to the contract terms negotiated by the Plan and Provider; however, if payment terms cannot be agreed upon within 10 days of the emergency transplant, then the transplant shall be paid at 150% of Medicare allowable and be considered payment in full. The transplanting hospital must provide the following documents to the Plan within 24 hours of the Emergency Transplant:

a) A letter from the transplanting hospital's Surgical Director detailing the medical conditions leading to the Emergency Transplant; and
b) A detailed contract proposal for the Emergency Transplant.

4. Prior Authorization Requirement for Organ Transplant**

Covered Expenses incurred in connection with any organ or tissue transplant covered by the Plan will be covered subject to referral to and prior authorization by the Plan Administrator's authorized review specialist, Medical Helpline. As soon as reasonably possible after a Plan Participant's physician has indicated that the Plan Participant is a potential candidate for a transplant, the Plan Participant or Plan Participant's physician should contact the Plan Administrator for referral to the medical review specialist for evaluation and prior authorization. A comprehensive treatment plan must be submitted for this Plan's medical review, and should include such information as diagnosis, the nature of the transplant, the setting of the procedure, (i.e., name and address of the hospital), any secondary medical complications, a five year prognosis, two (2) qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment. (One or both confirming second opinions may be waived by the Plan's medical review specialist.) Additional attending physician's statements may also be required. **All potential transplant cases will be assessed for their appropriateness for Case Management.**

****Failure to obtain prior authorization for a non-emergency transplant will result in all transplant expenses being excluded from coverage under the Plan.**

5. ***Covered Transplant Expenses***

The term "Covered Expenses" with respect to transplants includes the reasonable and necessary expenses for services and supplies which are covered under this Plan (or which are specifically identified as covered only under this provision) and which are medically necessary and appropriate to the transplant, including:

a) Charges incurred in the evaluation, screening, and candidacy determination process;
b) Charges incurred for organ transplantation;
c) Charges for organ procurement, including donor expenses not covered under the donor's plan of benefits.
   (i) Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ;
   (ii) Charges for organ procurement for a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow up care;

(iii) If the transplant procedure is a hematopoetic stem cell transplant, coverage will be provided for the cost of the acquisition of stem cells. This may be either peripherally or via bone marrow aspiration as clinically indicated, and is applicable to both the patient as the source (autologous) and related or unrelated donor as the source (allogeneic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs of the stem cells, up to the time of reinfusion. (The harvesting of the stem cells need not be performed within the transplant benefit period);

(d) Charges incurred for follow up care, including immuno-suppressant therapy; and

(e) Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual (over age 21), or in the event that the recipient or the donor is a minor (under age 21), two (2) other individuals (also over age 21). In addition, all reasonable and necessary lodging and meal expenses incurred during the transplant benefit period will be covered up to a maximum of $10,000 per transplant period.

(f) The following are specifically excluded travel expenses:

a. Travel costs incurred due to travel within 60 miles of your home;
b. Laundry expenses;
c. Telephone bills;
d. Alcohol or tobacco products;
e. Charges for transportation that exceed coach class rates
f. Child care, house sitting, or kennels;
g. Reimbursement for any lost wages; and
h. Charges in connection with the family support person, not incurred during the recipient's stay at the transplant facility.

6. Re-Transplantation

Re-transplantation will be covered up to one re-transplant, for a total of two transplants per person, per lifetime.

7. Donor Expenses

In-Network Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this Plan or any other benefit plan covering the donor. In addition, medical expense benefits for a donor who is not a participant under this Plan will be paid pursuant to the terms of a direct agreement or PPO agreement; if there is no direct agreement or PPO agreement, then the donor benefits are limited to a maximum of $10,000 per transplant benefit period when the transplant services are provided out of network. This does not include the donor's transportation and lodging expenses.

Preventive Care Services

As required by the Patient Protection and Affordable Care Act, the Plan covers preventive care services without cost-sharing to Plan Participants and their eligible and enrolled dependents. However, Braidwood Management, Inc. believes that certain mandates under the Patient Protection and Affordable Care Act violate its religious liberty under the United States Constitution as provided in the *Burwell v. Hobby Lobby* case. As such, the Plan intends to not cover certain preventive services and medications that have been identified as required by the

Patient Protection and Affordable Care Act, specifically any abortion or abortifacient contraceptives. The following services will be covered by the Plan effective at the beginning of the Plan Year following their adoption as a required service by the applicable entity:

- A and B Recommendations of the United States Preventive Services Task Force;
- Recommendations of the Advisory Committee on Immunization Practices that have been adopted by the Director of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources Services Administration (HRSA) for infants, children, and adolescents; and
- Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

Treatment of a condition identified through preventive care service is covered under the applicable Covered Services category at the cost-sharing for each Covered Services category. Prescription drugs covered as preventive are restricted to generics only, unless a generic version is unavailable or has been deemed medically inappropriate by the prescribing physician.

Preventive services under the Plan include, but are not limited to those specifically listed below. Please visit https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for more information about preventive services. This list of preventive services is subject to change with regulatory guidance.

Preventive Services for Adults

1. **Abdominal Aortic Aneurysm one-time screening** for men of specified ages who have ever smoked
2. **Alcohol Misuse screening and counseling**
3. **Aspirin use** to prevent cardiovascular disease for men and women of certain ages
4. **Blood Pressure screening** for all adults
5. **Cholesterol screening** for adults of certain ages or at higher risk
6. **Colorectal Cancer screening** for adults over 50
7. **Depression screening** for adults
8. **Diabetes (Type 2) screening** for adults with high blood pressure
9. **Diet counseling** for adults at higher risk for chronic disease
10. **Fall prevention:** exercise or physical therapy and vitamin D supplementation for older adults at increased risk of falls
11. **Healthy diet and physical activity counseling to prevent cardiovascular disease** for adults with cardiovascular risk factors
12. **Hepatitis B screening** for adults with a high risk of infection
13. **Hepatitis C screening** for adults with a high risk of infection
14. **HIV screening** for everyone ages 15 to 65, and other ages at increased risk
15. **Immunization vaccines** for adults--doses, recommended ages, and recommended populations vary:
    - Hepatitis A
    - Hepatitis B

- Herpes Zoster
- Human Papillomavirus
- Influenza (Flu Shot)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella

16. **Lung Cancer screening** for adults with a history of smoking
17. **Obesity screening and counseling** for all adults
18. **Statin preventive medication** for adults ages 40-75 years with no history of cardiovascular disease, 1 or more cardiovascular disease risk factors, and a calculated 10-year cardiovascular disease event risk of greater than 10%.
19. **Sexually Transmitted Infection (STI) prevention counseling** for adults at higher risk
20. **Syphilis screening** for all adults at higher risk
21. **Tobacco Use screening** for all adults and cessation interventions for tobacco users
22. **Tuberculosis Screening** for all adults in populations at an increased risk

Preventive Services for Women

1. **Anemia screening** on a routine basis for pregnant women
2. **Breast Cancer Genetic Test Risk Assessment and Counseling/Testing (BRCA)** for women who have family members with breast, ovarian, tubal and peritoneal cancer
3. **Breast Cancer Mammography screenings** every 1 to 2 years for women over 40
4. **Breast Cancer Chemoprevention counseling** for women at higher risk
5. **Breast Cancer Preventive Medications** for women at higher risk
6. **Breastfeeding comprehensive support and counseling** from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
7. **Cervical Cancer screening** for women ages 21 to 65
8. **Chlamydia Infection screening** for younger women and other women at higher risk
9. **Contraception**: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers."
10. **Domestic and interpersonal violence screening and counseling** for all women
11. **Folic Acid** supplements for women who may become pregnant
12. **Gestational diabetes screening** for pregnant women after 24 weeks and those at high risk of developing gestational diabetes
13. **Gonorrhea screening** for all women at higher risk
14. **Hepatitis B screening** for pregnant women at their first prenatal visit
15. **HIV screening and counseling** for sexually active women
16. **Human Papillomavirus (HPV) DNA Test** every 3 years for women with normal cytology results who are 30 or older
17. **Osteoporosis screening** for women over age 65 years or younger depending on risk factors
18. **Preeclampsia screening:** The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.

19. **Preeclampsia prevention:** The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.
20. **Rh Incompatibility screening** for all pregnant women and follow-up testing for women at higher risk
21. **Sexually Transmitted Infections counseling** for sexually active women
22. **Syphilis screening** for all pregnant women or other women at increased risk
23. **Tobacco Use screening and interventions** for all women, and expanded counseling for pregnant tobacco users
24. **Urinary tract or other infection screening** for pregnant women
25. **Well-woman visits** to get recommended services for women under 65

Preventive Services for Children

1. **Alcohol, tobacco, and drug use assessments** for adolescents.
2. **Autism screening** for children at 18 and 24 months
3. **Behavioral assessments** for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
4. **Bilirubin concentration screening** for newborns.
5. **Blood Pressure screening** for children at the following ages: 0 to 11 months, 1 to 4 years , 5 to 10 years, 11 to 14 years, 15 to 17 years.
6. **Blood screening** for newborns.
7. **Cervical Dysplasia screening** for sexually active females.
8. **Depression screening** in adolescents aged 12 to 18 years.
9. **Developmental screening** for children under age 3.
10. **Dyslipidemia screening** for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
11. **Fluoride Chemoprevention supplements** for children without fluoride in their water source.
12. **Fluoride varnish** for all infants and children as soon as teeth are present.
13. **Gonorrhea preventive medication** for the eyes of all newborns.
14. **Hearing screening** for all newborns; and for children once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years.
15. **Height, Weight and Body Mass Index measurements** for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
16. **Hematocrit or Hemoglobin screening** for children.
17. **Hemoglobinopathies for sickle cell screening** for newborns
18. **Hepatitis B screening** for adolescents at higher risk
19. **HIV screening** for adolescents at higher risk
20. **Hypothyroidism screening** for newborns
21. **Immunization vaccines** for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis
    - Haemophilus influenza type b
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus (HPV)

- Inactivated Poliovirus
- Influenza (Flu Shot)
- Measles
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella (Chickenpox)

22. **Iron supplements** for children ages 6 to 12 months at risk for anemia.
23. **Lead screening** for children at risk of exposure.
24. **Medical History** for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years , 5 to 10 years , 11 to 14 years , 15 to 17 years.
25. **Obesity screening and counseling** for age 6 years or older.
26. **Oral Health risk assessment** for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
27. **Phenylketonuria (PKU) screening** for this genetic disorder in newborns.
28. **Sexually Transmitted Infection (STI) prevention counseling and screening** for adolescents at higher risk.
29. **Tuberculin testing** for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
30. **Vision screening** for all children.

Charges for Well Child Care. Well childcare includes routine pediatric care and immunizations by a Physician that is not for an Injury or Sickness.

Coverage of Well Newborn Nursery/Physician Care
Charges for Routine Newborn Nursery Care. Routine well newborn nursery care is room, board and other normal care, including a surgeon's charge for circumcision for which a Hospital makes a charge.

The Allowable Charge made by the Hospital for routine nursery care provided as shown below after the newborn child's birth will be considered as covered charges under the Plan.

All routine well newborn charges are billed as, and considered part of, the mother's claim for the delivery. This coverage is only provided if a parent is a Plan Participant who was covered under the Plan at the conclusion of the Pregnancy and the newborn child is an eligible Dependent and is neither injured nor ill.

Coverage for a Hospital stay following a normal vaginal delivery will be 48 hours for both the mother (if a Plan Participant) and the newborn child unless a shorter stay is agreed to by both the mother and her attending Physician. Coverage for a Hospital stay in connection with childbirth following a Caesarean section will be 96 hours for both the mother (if a Plan Participant) and the newborn child unless a shorter stay is agreed to by both the mother and her attending Physician. In any case, plans and issuers may not, under Federal Law, require that a provider obtain authorization from the plan or the issuers for prescribing a length of stay not in excess of 48 hours

(or 96 hours for Caesarean delivery). Longer stays may be requested through the Plan's Utilization Review Procedure.

Charges for Routine Physician Care. The benefit is limited to the Reasonable and Necessary Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Coverage of Pregnancy
The Reasonable and Necessary Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for the Employee and the Spouse only. Pregnancy expenses for a dependent child are not covered under this Plan.

Coverage for a Hospital stay following a normal vaginal delivery will be 48 hours for both the mother (if a Plan Participant) and the newborn child unless a shorter stay is agreed to by both the mother and her attending Physician. Coverage for a Hospital stay in connection with childbirth following a Caesarian section will be 96 hours for both the mother (if a Plan Participant) and the newborn child unless a shorter stay is agreed to by both the mother and her attending Physician. In any case, plans and issuers may not, under Federal Law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours for Caesarian delivery). **(Federal Newborn and Mothers Health Protection Act).** Longer stays may be requested through the Plan's Utilization Review Procedure.

Pre-Existing Conditions
Pursuant to the Affordable Care Act, the Plan will not impose pre-existing condition exclusions on an eligible Employee or Dependent. For the purposes of this section, Pre-existing condition exclusion means a limitation or exclusion of benefits (including the denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) whether or not any medical advice, diagnosis, care or treatment was recommended or received before that day.

MEDICAL PLAN EXCLUSIONS AND LIMITATIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is <u>NOT</u> covered:

Acupuncture. Services for acupuncture that is not **Medically Necessary** and not provided by a Physician (M.D.).

Biofeedback Therapy. Services provided during biofeedback.

Certain Care Facilities. Services provided by an institution which is primarily a rest home, a place for the aged, a nursing home, a convalescent home (other than a convalescent facility for

extended care due to a covered illness or injury), a place of custodial care, or any other place of like character.

Certain Testing, Counseling or Therapy Psychological testing, marriage or family counseling, group therapy or group activities (i.e., occupational, recreational, etc.), unless otherwise stated in this Plan Document.

Charges incurred outside the United States. Charges incurred outside the United States if the Covered Participant traveled to such location for the purpose of obtaining medical services, medications, or supplies unless the services are Medically Necessary, negotiated, and approved by the Plan in advance of service.

Childhood Behavioral, Developmental, and Learning Problems. Services for the treatment of childhood behavioral problems, developmental delay, learning disabilities and services related to the childhood inpatient confinement for environmental change. This exclusion applies whether or not the child has a disability such as autistic disease, hyper kinetic syndromes, learning disabilities, and mental retardation. However, this exclusion shall not apply to (1) charges incurred for prescription drugs used in the treatment of behavioral problems; or (2) to the following medically necessary services rendered solely for medication checks required as a result of taking medication for the treatment of ADD/ADHD: (a) Physician office visit(s), and (b) laboratory examination(s).

Chiropractic Care. Charges which exceed the amount provided in the Schedule of Benefits, if any, for services which are related to Chiropractic Care.

Complications of non-covered treatments. Care, services or treatment required as a result of complications from a treatment not covered under the Plan.

Contraception. A charge for contraceptive devices, contraceptive materials, or oral contraceptive medications.

Cosmetic services. Services or supplies to improve appearance or self perception which does not restore a bodily function, including but not limited to cosmetic or plastic surgery, hair loss or skin wrinkling, unless **Medically Necessary**. This exclusion will not apply if the care and treatment is for:

a. Repair of disfigurement resulting from an accidental injury sustained by the patient and treatment is begun within ninety (90) days after the accident in which the injury is sustained, unless it was not possible to do so within this time limit; or

b. Treatment for correction of a congenital defect of a child less than 19 years of age.

Court Ordered Exams. Any exams or treatment which a Plan Participant has been ordered by a court, judge or any other legal authority to undergo, unless it is Medically Necessary and otherwise covered by the Plan.

Custodial care. Services or supplies provided mainly as a rest cure or maintenance care such as sitters, homemaker services, education or training.

Dental. Charges incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or a molar process and any other dental, orthodontic, or oral surgical charges unless expressly included elsewhere in this Plan document.

Detoxification. Treatment solely for detoxification or primarily for maintenance care is not considered effective treatment. Detoxification is care aimed primarily at overcoming the after effects of a specific drinking or drug episode. Maintenance care consists of the providing of an alcohol-free or drug-free environment.

Driving Under the Influence. Charges incurred when the Plan Participant was driving a motor vehicle and his/her blood-alcohol level as indicated in the medical records is over the legal limit in the state where the Plan Participant was driving.

Drug Screening. Baseline drug screenings are covered for the initial testing when a patient is prescribed a medication that requires monitoring for long term drug usage. Random drug screenings performed in the physician's office for monitoring medication usage are limited to one per quarter.

EAP and behavioral health. Employee Assistance and behavioral health services are excluded unless specifically shown in the Schedule of Benefits.

Excess charges. Where the Plan does not have a pre-payment or preferred provider agreement with a medical provider, charges which exceed the Reasonable and Necessary charges of the individual or organization for the services, medicines, or supplies furnished.

Exercise programs. Exercise or therapy programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by the Plan.

Experimental or Investigational Services/Treatments. Procedures, drugs or research studies, or for any services or supplies that are not considered legal in the United States or whose use is limited to experimental or investigational purposes by laws or regulations under State or Federal law.

Eye care. Lasik, radial keratotomy or other eye surgery to correct nearsightedness. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

Foot care. Care and treatment of:

(a) weak, strained, flat, unstable or unbalanced feet;

(b) superficial lesions of the feet such as corns, calluses or hyperkeratosis; tarsalgia, metatarsalgia or bunion, except Surgery which involves exposure of bones, tendons or ligaments; and
(c) toenails, except removal of nail matrix; and
(d) arch supports, heel wedges, lifts the fitting or provision of Orthotics or orthopedic shoes, except as an integral part of a brace.

This exclusion does not apply to the initial office visit nor treatment of a metabolic or peripheral-vascular disease.

Genetic Testing. Genetic testing will not be covered unless medically necessary and Plan Participants have received genetic counseling prior to the testing. Prenatal genetic testing will be covered where the mother is 35 years of age or older, or if the mother or father has a family history that establishes him/her as at-risk for having a hereditary genetic disorder. This exclusion of Genetic testing does not apply to the BRCA risk assessment and genetic counseling/testing requirement of the women's preventive care mandate of the ACA.

Government coverage. Services or supplies received in a hospital owned or operated by the United States government, State government or any of its agencies, except to the extent, if any, that charges are made for such services or supplies which the plan participant would be required to pay if this plan were not in effect. This exclusion shall not apply where Federal law mandates this plan to provide coverage. (See also Medicare/Medicaid)

Habit. Services or supplies furnished for the purpose of breaking a "habit" (i.e., smoking, overeating, thumb sucking, etc.). This exclusion does not apply to preventive services required by PPACA.

Hair loss. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, unless the wig is to treat hair loss resulting from chemotherapy or radiation therapy.

Hearing aids and exams. Charges for services or supplies in connection with hearing aids or exams for their fitting. This exclusion shall not apply to the initial purchase of a hearing aid if the loss of hearing is the result of a surgical procedure.

Hospital confinement. Inpatient admissions when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, and any routine physical examination or test performed while the participant is an inpatient and which are not connected with the actual illness or injury.

Hospital employees. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

Hypnosis. Treatment by hypnosis or any type of goal-oriented or behavior modification therapy, such as to (but not limited to) quit smoking or weight loss, except as part of the Physician's treatment of a mental illness or when hypnosis is used in lieu of an anesthetic.

Illegal acts. Charges for services received as a result of Injury or Sickness while engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. Also includes services, supplies, care or treatment to a Covered Person for an Injury or Sickness that occurred while a Covered Person was illegally using of alcohol. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol. This exclusion will only apply if the illegal act was not a result of physical or mental illness or domestic violence. ***A final determination of guilt by a court of law is not necessary for this exclusion to apply.***

Infertility/Impotence. Care and treatment for infertility, artificial insemination, surrogate mother or in vitro fertilization. Fertility drugs, sex transformations, and reversal of a sterilization procedure. Treatment of male impotence including medications such as phosphodiesterase type inhibitors, including but not limited to Viagra or other sildenafil citrate medications. This exclusion shall not apply to hormone replacement therapy if medically necessary.

Intraoperative Monitoring. Intraoperative monitoring will not be covered unless Medically Necessary.

Massage Therapy. Charges for massage therapy (other than for treatment of an illness or injury and consistent with an approved treatment plan) when not prescribed by a Physician or provided by a licensed provider. See definition of Physician.

Medical Advice. Charges incurred as a result of a participant ignoring, disregarding, or otherwise refusing to follow, except for religious reasons, generally accepted medical advice concerning any medical treatment which an ordinarily prudent person would not ignore, disregard or otherwise refuse to follow, except for religious reasons.

Medical Devices/Implants. Charges for medical devices/implants will be limited as follows:
Network Providers
Charges for medical devices/implants from network providers will be reimbursed at the PPO Allowable Amount.

Non-Network Providers
Total charges for medical devices/implants from non-network providers will be paid according to the Plan Allowable Amount.

Medically Necessary. Services and supplies that are determined not to be Medically Necessary.

Medicare/Medicaid. For any condition, disease, aliment, injury or diagnostic service to the extent that benefits could be provided by Medicare or any other tax supported or government program except when State or Federal law requires this Plan to pay primary to benefits of such programs. In no event shall the benefits of this program paid under provision of law exceed the lesser of the benefits of this program in absence of such tax supported or government program(s).

Mental/Nervous and Substance Abuse Disorders. Charges for care and treatment of Mental/Nervous and Substance Abuse Disorders.

Missed Appointment. Charge for missed appointment, completion of claim forms or providing medical information to determine coverage, and/or charges for telephone consultation are not covered under this Plan.

Naturopathy. Services provided in connection with naturopathy.

No charge. Services or supplies for which the covered person is not legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

Non-emergency Hospital admissions. Care and treatment billed by a Hospital for non-emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

No obligation to pay. Charges incurred for which the Plan has no legal obligation to pay.

No Physician recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment, which is appropriate care for the Injury or Sickness.

Not specified as covered. Services, treatments and supplies, which are not specified as covered under this Plan.

Nuclear exposure. Any illness or injury caused by atomic explosion or other release of nuclear energy whether or not the result of war.

Nutritional supplements. Nutritional supplements not necessary for the treatment of an accident or illness.

Obesity. Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. This exclusion does not apply to dietary and weight loss counseling covered as a preventive service.

Occupational. Care and treatment of an Illness or Injury that is occupational (arises from work or any employment for wage or profit including self-employment) and any related medical, vision, or dental claim is reimbursed in whole or in part under a Workers' Compensation program, short-term disability plan, long-term disability plan and/or some other work or non-work related plan, program, policy or other form of compensation.

Orthognatic Surgery. Charges related to orthognatic surgery – surgery to correct congenital or developmental maxillofacial skeletal deformities of the mandible and maxilla after the participant's 19th birthday.

Personal comfort items charges (when hospital confined). Personal comfort items or other equipment, such as, but not limited to, television, telephone, beautification items, admission kits, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and non-hospital adjustable beds.

Physicians' charges. Charges for physicians' fees for any treatment which are not ordered or rendered by or in the physical presence of a licensed physician. This exclusion shall not apply to automated lab fees.

Plan Design exclusions. Charges excluded by the Plan design as mentioned in this document.

Pregnancy of daughter. Care and treatment of Pregnancy and Complications of Pregnancy for a dependent daughter only. This exclusion shall not apply to any service covered under Preventive Care Services.

Professional nursing services. Charges for professional nursing services, except as listed in the Schedule of Benefits, if rendered by someone other than an **RN** (registered graduate nurse) or a **LPN** (licensed practical nurse).

Relative giving services. Professional services performed by a Physician (see definition of Physician) who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Replacement braces. Replacement of braces for the leg, arm, back, neck, or artificial arms or legs unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

Robotic Surgery. Charges related to the use of robotics during surgery will not be covered unless the use of robotics is Medically Necessary.

Routine care. Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

Self-Inflicted. Charges incurred in connection with any intentionally self-inflicted injury or illness, suicide or attempted suicide, but only if the injuries do not result from a physical or mental illness or domestic violence.

Services before or after coverage. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

Services, Supplies, or Treatment, or any combination thereof, not approved by the FDA or the NCCN Services, supplies, or treatment not recognized by the Food and Drug Administration or the National Comprehensive Cancer Network as generally accepted and medically necessary for the diagnosis.

Sex changes. Care, services or treatment for non-congenital transsexuals, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, and hormone therapy, and surgery, medical or psychiatric treatment.

Sleep disorders. Care and treatment for sleep disorders unless deemed **Medically Necessary**.

Speech Therapy. Speech therapy except services provided by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy); (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder. The developmental speech problems of a child would not qualify for coverage.

Surgical sterilization reversal. Care and treatment for reversal of surgical sterilization.

Temporomandibular Joint Syndrome. All diagnostic, surgical and non-surgical treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.

Transplants. Services related to whole organ transplants, to the extent the transplant should be excluded under the Non-AMA/Non-FDA exclusion/limitation, and ancillary charges related to such services (i.e. Donor Bank fees).

Travel or accommodations, except as may be indicated in the plan, whether or not recommended by a physician, except for ambulance charges as defined as a covered expense.

War. Charges incurred as a result of war or any act of war, declared or not; or caused during service in the armed forces of any country except as required by the Uniformed Services Employment and Reemployment Right Act.

PRESCRIPTION DRUG BENEFITS

How Do I Use My Prescription Drug Benefit?

Your Prescription Drug Benefit helps to cover the cost for some of the medications prescribed by a Participating Physician. Using your benefit is simple;

· Present your prescription and ID card at any Participating Pharmacy.
· Pay the Copayment for a Prescription Unit or its retail cost, whichever is less.

· Receive your medication

When I Fill a Prescription, How Much Medication Do I Receive?

Retail:

For a single Copayment, Members receive either one Prescription Unit or up to a 30-day supply of a drug. For maintenance medications, you make one (1) Copayment for each Prescription Unit or every 30-day supply; however, you can fill your prescription for two Prescription Units or 31-60 day supply for two (2) Copayments, or for three Prescription Units or 61-90 day supply for three (3) Copayments. *Copayments will vary by Plan*.

Mail:

If you use the Mail Service Pharmacy Program, you will receive three (3) Prescription Units or up to a 90 day supply of maintenance medications for a single copayment. *Copayment will vary by Plan.*

Plan Prior Authorization (PA), Quantity Limits (QL), and Age Restrictions for Selected Drugs.

Selected drugs are subject to Prior Authorization to determine that they are medically necessary and being prescribed according to treatment guidelines consistent with good professional practice. Other drugs include a quantity limits or age restrictions. These include but not limited to:

- Drugs to treat ADD/ADHD, oral and patch: PA required only if patient is less than age 6. No coverage after age 26. Vyvanse requires a PA for patients equal to or greater than age 6.
- Anaphylaxis Kits (Epinephrine / Epipen): Quantity Limit of 4 pens per year
- Extended Cycle Contraceptives, example Seasonale: Mail order = 84 day supply and Retail requires three (3) Copayments.
- Acne oral and topical Retinoid covered to age 25.
- Cough/Cold/Allergy Misc. limited to a 14 day supply
- Growth Hormone requires a PA for coverage

For a complete list of the selected medications, please contact Southern Scripts at 1-800-710-9341.

What Else Do I need to Know?

Formulary (Preferred) Drug List: You should become familiar with the Prescription Drug Formulary (Preferred list). Any medication not on our formulary (Preferred list) but not excluded from coverage may be subject to the higher non-Formulary (non-Preferred) Copayment.

Covered Medications

The following medications are included in the managed Formulary (Preferred) and are available to your Participating Physicians. Your benefit also includes non-Formulary (non-Preferred) drugs for the non-Formulary (non-Preferred) Copayment when ordered by a Participating Physician and filled at a Participating Pharmacy.

1. Federal Legend Drugs: Any medicinal substance which bears the legend: "Caution: Federal

Law prohibits dispensing without a prescription."

2. State Restricted Drugs: Any medicinal substance that may be dispensed by prescription only according to State Law.
3. Diabetic supplies to include: alcohol swabs, blood glucose test strips, Insulin Syringes, Lancets, Lancing Devices, Pen Needles.
4. Vacation Supplies of Prescription Drugs
5. Federal Legend Smoking Cessation drugs including, but not limited to Chantix.
6. Prescription Vitamins that include: Fluoride, Folic Acid, Iron, Prenatal, B-12, D, and K.

Prescription Exclusions and Limitation

While the Prescription Drug Benefit covers most medications, there are some that are not covered.

1. Drugs or medications purchased and received prior to the Member's effective date or subsequent to the Member's termination.
2. Therapeutic devices or appliances including hypodermic needles, syringes (except insulin syringes), support garments, and other non-medicinal substances.
3. All non-prescription (over-the-counter) contraceptive jellies, ointments, foams or devices.
4. Medications to be taken or administered to the eligible Member while a patient in a hospital, rest home, nursing home, sanitarium, etc.
5. Drugs or medicines delivered or administered to the Member by the prescriber or the prescriber's staff.
6. Dietary supplements, including vitamins (excepts prescription prenatal, Folic Acid/Folates, Iron, B-12, D, and K), health or beauty aids, herbal supplements and/or alternative medication.
7. Compounded Medication: Any medicinal substance that has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount. All compounded medications are subject to the prior authorization process.
8. Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to a patient.
9. Medication prescribed for experimental or investigational therapies.
10. Off-label Drug Use: Off-Label Drug Use means that the Provider has prescribed a drug approved by the Food and Drug Administration (FDA) for a use that is different than that for which the FDA approved the drug.
11. Medications available without a prescription (over-the-counter) or for which there is a non-prescription equivalent available, even if ordered by a physician.
12. Elective or voluntary enhancement procedures, services, supplies and medications, including but not limited to: Blood Glucose Monitors, Ketone Monitoring Supplies, Respiratory Therapy Supplies, weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes (exception of Retin A to age 25), anti-aging and mental performance.
13. Medications prescribed by non-Participating Physicians (except for prescriptions required as a result of an Emergency or Urgently Needed Service for an acute condition).
14. Medications dispensed by a non-Participating Pharmacy (except for prescriptions required

as a result of an Emergency or Urgently Needed Service for an acute condition).
15. Drugs for diagnostic purposes.
16. Replacement of lost, stolen or destroyed medications.
17. Intravenous Medications.
18. Medications while incarcerated.
19. Repackaged Medications.
20. Hemophilia Factor
21. Drugs for Infertility
22. Wound Care Products
23. Vaccines except as included in the Schedule of Benefits
24. Allergens/Allergy Injections
25. Drugs for Chemical Dependency
26. Dental Fluoride Preparations.
27. Abortifacients
28. Anorexiants
29. Immunization Agents (except as required by the ACA and administered on an outpatient basis)
30. Schedule I Controlled Substances

"ME TOO" Drugs Excluded

"ME TOO" drugs are chemically-similar drugs that share the same mechanism of action to a less expensive existing approved chemical entity. ME TOO drugs offer no significant clinical benefit. This list of drugs includes but is not limited to medications for the treatment of Acne, ADHD, Contraception, Estrogen replacement, Gout, Anti-fungals, and Nausea.

Please call Southern Scripts at 1-800-710-9341 with any questions or for a complete list of these medications. This list will be updated from time to time as new drugs enter the market place.

Non-Essential Drugs Excluded

Non-Essential drugs are medications in a dosage form that increases the cost for treatment, when other less expensive dosage forms are available. Example: Topical Patches, Creams. This list of drugs includes but is not limited to medications for the treatment of minor aches and pain and muscle soreness.

Please call Southern Scripts at 1-800-710-9341 with any questions or for a complete list of these medications. This list will be updated from time to time as new drugs enter the market place.

ASK A NURSE

PERSONAL HEALTH MANAGEMENT
PHONE: 1-877-463-3435

Your Employer is introducing a benefit to help you and your family with questions and concerns about medical care. Ask a Nurse/Personal Health Management, a service offered by Medical Helpline not only provides you with the surgical and hospital authorizations you have always needed, but can now provide you with information, education, and counseling about medical issues you may be facing. This program is staffed by Registered Nurses ready to help you.

Ask a Nurse/Personal Health Management helps you find doctors and facilities that are members of your PPO Network. When you use a network provider for medical services you are protected against uncontrolled medical costs, which you may otherwise have to pay.

There is no cost to you to use Ask a Nurse/Personal Health Management

When you call the toll free line **1-877-463-3435**, you will have access to a comprehensive health information program that combines confidential, non-directive health care decision counseling by registered nurses, medical information and easy to read educational material, as well as authorization for planned inpatient services.

After speaking with the nurse, you will be better informed and able to make wiser choices concerning the health care services you use. The nurse can provide you with information in English or Spanish.

The nurse does not replace your doctor, but she or he will help improve communication with your doctor. Doctors have spent many years in medical school, read medical journals, and attend conferences to keep up with the latest medical information. You may think you have nothing to contribute to your own medical care. Think again! Doctors treat hundreds of patients a year. You are the expert when it comes to your family history, symptom lifestyle preferences, concerns and fears. By allowing Ask a Nurse/Personal Health Management to help you do your homework and by fully understanding the benefits, risks and costs to you of a proposed treatment, you can select the option best suited to your needs. Few medical procedures are actually emergencies, there is usually time to explore your options and select the one that best suits you.

Nurses are available to you 24 hours a day. You may contact them as frequently as you wish. Your calls are kept strictly confidential and since records are maintained once you have made the first call, the nurse is able to give more personalized counseling.

We are pleased to offer you the Employer-sponsored Ask a Nurse/Personal Health Management program and have designed it to assist you in making educated decisions about you and your family's health.

MEDICAL MANAGEMENT SERVICES

Medical Management Services Phone Number (877) 463-3435

The patient, a family member or service provider must call this number to receive authorization of certain Medical Management Services. This call must be made at least five (5) business days in advance of services being rendered or within two (2) business days after an emergency.

Prior Authorization/Utilization review
Prior Authorization/Utilization review is a program designed to help insure that all Plan Participants receive necessary and appropriate health care while avoiding unnecessary expenses.

This program consists of:

(a) Prior Authorization of the Medical Necessity for the following non-emergency services:
- Hospitalizations

(b) Retrospective review of the Medical Necessity of the services provided when deemed necessary;
(c) Concurrent review, based on the admitting diagnosis, of the services requested by the attending Physician; and
(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what is payable by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

It is ultimately the responsibility of the Plan Participant to make sure that the provider complies with the Prior Authorization/Utilization Review requirements.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Prior Authorization. Before a Plan Participant enters a Medical Care Facility on a non-emergency basis or receives other medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Plan Participant, family member or service provider. Contact the utilization review administrator at:

Medical Helpline
(877) 463-3435

at least five (5) business days before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered employee.
- The name, Social-Security number and address of the covered employee.

- The name of the Employer.
- The name and telephone number of the attending Physician.
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay.
- The diagnosis and/or type of surgery.
- The proposed medical services to be rendered.

If there is an emergency admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact Medical Helpline within two (2) business days after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services as appropriate.

Proper authorization must be obtained in a timely manner.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Plan Participant's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Plan Participant either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services. **It is ultimately the responsibility of the Plan Participant to make sure that the provider complies with the Prior Authorization/Utilization Review requirements.**

If the attending Physician feels that it is **Medically Necessary** for a Plan Participant to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been Prior Authorized, the attending Physician must request the additional services or days.

Voluntary Second and/or Third Opinion Program
Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Plan Participants and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Mastectomy Surgery
Cataract Surgery	Prostate Surgery
Cholecystectomy (Gall Bladder Removal)	Salpingo Oophorectomy (Removal of Tubes/Ovaries)
Deviated Septum	Spinal Surgery
Hemorrhoidectomy	Surgery (Knee, Shoulder, Elbow or Toe)
Hernia Surgery	Tonsilectomy & Adenoidectomy
Hysterectomy	Tympanotomy
	Varicose Vein Ligation

Pre-Admission Testing Service
The Medical Benefits percentage payable will be the Network and Non-Network coinsurance levels for diagnostic lab tests and x-ray exams when:

(1) Performed on an outpatient basis within seven days before a Hospital confinement;
(2) Related to the condition which causes the confinement; and
(3) Performed in place of tests while Hospital confined.

Covered charges for this testing will be payable even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

Case Management
When a catastrophic condition, such as a spinal cord injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps, lifetime care. After the person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting – even to his or her home.

Case Management is a program whereby a case manager monitors these patients and explores, discusses and recommends coordinated and/or alternate types of appropriate **Medically Necessary** Care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- Personal support to the patient;
- Contacting the family to offer assistance and support;
- Monitoring Hospital or nursing home care;
- Determining alternative care options; and
- Assisting in obtaining any necessary equipment and services.

Case Management occurs in the following situations:

(1) The catastrophic Injury or Sickness must have occurred while the patient was covered.
(2) An alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for **Medically Necessary** expenses, as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Alternative Care Program

In addition to the benefits specified, the Plan also offers benefits for services furnished by any provider to a Covered Person pursuant to an Alternative Care program. The Alternative Care program applies to a Covered Person who has suffered a personal injury, sickness, or other health condition while covered under the Plan. ***A "personal injury, sickness, or other health condition" is defined as an illness, injury, impairment, or physical or mental condition that involves outpatient care; or inpatient care in a hospital, hospice, or residential medical care facility; or continuing treatment by a health care provider.*** The Case Manager will coordinate and implement this Alternative Care program by providing guidance and information on available resources and suggesting the most appropriate alternative treatment plan. This alternative treatment plan must be approved by both the Plan and the Case Manager.

The Plan shall provide such alternative benefits for so long as it determines that alternative services are Medically Necessary and cost-effective. Severity of the Covered Person's personal injury, sickness, or other health condition and the prognosis will be taken into consideration. The Plan shall have the right to waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result without sacrifice to the quality of patient care. However, certain time and dollar amount limitations may still apply to the approved alternative treatment plan even if the alternative services continue to be Medically Necessary and cost-effective.

If a covered person is accepted into an alternative treatment plan, the Plan will pay benefits for Allowable Charges. The Plan will determine the amount of benefits, and said benefits may exceed policy limitations and may extend beyond the types of expenses covered by the Plan.
Any agreement to pay benefits in accordance with the above will be based on an objective review of:

1. the covered person's medical status;
2. the current treatment plan;
3. the projected treatment plan;;
4. the long term cost implications; and
5. the effectiveness of care.

An alternative treatment plan may be terminated at any time, including, but not limited to, when the covered person has improved or deteriorated to the extent that the alternative services are no longer necessary and cost-effective, the individual's coverage under the Plan ends.

An alternative treatment plan will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that Covered Person. If an alternative treatment plan is provided for a Covered Person in one instance, the Plan shall not be obligated to provide the same or similar benefits for other covered persons under this Plan in any other instance, nor shall it be construed as a waiver of the right of the Plan thereafter in strict accordance with its express terms.

CLAIMS PROCEDURES

In the event federal, state, or case law alters how a claim should be paid according to the terms and provisions of the Plan Document and Summary Plan Description, then the claim will be processed according to such law.

Types of Claims

A "claim" is a request for a benefit made by a claimant in accordance with the Plan's claims procedures. There are four different types of claims that may be submitted to the Plan.

i. Urgent Care Claims – these are claims where failing to make a quick determination of coverage could seriously jeopardize the life or health of a claimant, or his or her ability to regain maximum function, or could subject a claimant to sever pain that could not be managed without the treatment that is the subject of the claim. Any claim that a ***physician*** (with knowledge of a claimant's condition) considers to be urgent is deemed an urgent care claim.

ii. Pre-Service Claims – these are claims where participants are required to obtain approval before obtaining care. An example of this would be a request for prior approval of a treatment plan for physical therapy after a broken leg.

iii. Post-Service Claims – these claims are where service has already been rendered. Many, if not most claims, will fall into this category.

iv. Concurrent Claims – these claims occur when claims are reconsidered after the initial approval was made and results in a reduced or terminated benefit. An example of this would be an inpatient hospital stay originally certified for five days that is reviewed at three days to determine if the full five days is appropriate.

Determination of Claims

Urgent Care Claims. For "Urgent Care Claims," the Plan shall notify the claimant of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan shall notify the claimant as soon

as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan shall notify the claimant of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

(A) The Plan's receipt of the specified information, or

(B) The end of the period afforded the claimant to provide the specified additional information.

Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with the Notification of Adverse Benefits section below.

Pre-Service Claims. For "Pre-Service Claims," the Plan shall notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with the Notification of Adverse Benefits section below.

Post-Service Claims. For "Post-Services Claims," the Plan shall notify the claimant, in accordance with the Notification of Adverse Benefits section below, of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Concurrent Claims. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

(A) Any reduction or termination by the Plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of

treatments shall constitute an adverse benefit determination. The Plan shall notify the claimant, in accordance with the Notification of Adverse Benefits section below, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

(B) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Plan shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with the Notification of Adverse Benefits section below.

Notification of Adverse Benefits. The Plan shall provide a claimant with written or electronic notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant:

i. The specific reason or reasons for the adverse determination;
ii. Reference to the specific plan provisions on which the determination is based;
iii. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
iv. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on review;
v. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
vi. If a claim involves urgent care, a description of the expedited review process applicable to such claims.

In the case of an adverse benefit determination by the Plan concerning a claim involving urgent care, the information described in the above section may be provided to the claimant orally within the time frame prescribed in the Urgent Care Claims section above, provided that a written or

electronic notification in accordance with this section is furnished to the claimant not later than 3 days after the oral notification.

Claims Review Procedure
In cases where a claim for benefits payment is denied in whole or in part, the claimant may appeal the denial. This appeal provision will allow the claimant to:

(1) Request from the Plan a review of the eligibility status for any claim denied in whole or in part.
(2) Request from the Plan a review of any claim payment. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.
(3) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan or Contract administrator within 180 days after the claim payment date or the date of the notification of denial of benefits.

In the case of an Urgent Care Claim, the Plan shall notify the claimant of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the Plan.

In the case of a Pre-Service Claim, the Plan shall notify the claimant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than 30 days after receipt by the plan of the claimant's request for review of an adverse benefit determination.

In the case of a post-service claim, the Plan shall notify the claimant of the Plan's benefit determination on review within a reasonable period of time. Such notification shall be provided not later than 60 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination.

The Patient Protection and Affordable Care Act (“PPACA”) expanded the definition of “adverse benefit determination” to include rescission of coverage (see number 5 below); therefore, “Adverse benefit determination” means the following:

1. a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit;
2. a denial based on a determination of a participant’s or beneficiary’s eligibility to participate in the Plan;
3. a failure to provide or make payment for a benefit resulting from the application of any utilization review;
4. a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; and,

5. rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at that time).

How to Submit a Claim
When a Plan Participant has a claim to submit for payment that person must:

(1) Obtain a claim form from the Personnel Office or the Plan Administrator.
(2) Complete the Employee portion of the form. ALL QUESTIONS SHOULD BE ANSWERED.
(3) Have the Physician complete the provider's portion of the form.
(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Group Number of Plan
- Employee's Name
- Name of Patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Contract administrator at this address:
Entrust, Inc.
22322 Grand Corner Drive, Suite 200
Katy, TX 77494

When Claims Should be Filed
This section applies to Post-Service Claims only
For "Post-Service Claims," claims should be filed with the Contract Administrator within twelve (12) months from the date the charges for the services were incurred to be covered by the plan. Benefits are based on the Plan's provisions at the time the charges were incurred. Charges are considered incurred when a treatment or care is given or a procedure performed. The Contract Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

Appeal of Final Internal Adverse Determination
Any party whose appeal of an adverse benefit determination is denied may seek review of the decision by an Independent Review Organization ("IRO"). You or your designated representative may contact the Contract Administrator to request a review of such denial by an IRO. The request must be made in writing, stating in clear and concise terms the reason that you are appealing the Final Internal Adverse Benefit Determination.

You may request an immediate appeal to an IRO in the event of a medical condition that would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function or concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. When a Plan Participant is covered by this Plan and another plan, or the Plan Participant's Spouse is covered by this Plan and by another plan or the couple's Covered Children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will either pay its regular benefits in full or a reduced amount which when added to the Plan or Plans, will in most cases, equal 100% of eligible expenses under the provisions of this Plan.

Benefit Plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.
(2) Blue Cross and Blue Shield group plans.
(3) Group practice and other group prepayment plans.
(4) Federal government plans or programs. This includes Medicare.
(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Reasonable and Necessary Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) plans: This Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Also, when an HMO pays its benefits first, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO had the Plan Participant used the services of an HMO provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Benefit Plan Payment Order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits by these rules up to the allowable charge.

(a) The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that; if the person is also a Medicare Beneficiary and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is

(i) Secondary to the plan covering the person as a dependent, and

(ii) Primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the benefits of the Plan covering that person as other than a dependent.

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid-off or retired are determined before those of a benefit plan which covers a person as a Dependent of a laid-off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid-off nor retired or a Dependent of an Employee who is neither laid-off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan, which has covered the patient for the longer time, are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) *This rule applies when the parent with custody of the child has not remarried.* The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) *This rule applies when the parent with custody of the child has remarried.* The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) *This rule will be in place of items (i) and (ii) above when it applies.* A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outline above when a child is covered as a Dependent and the parents are not separated or divorced.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payor, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims Determination Period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Plan Participant will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of Payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case, this Plan may recover the amount paid from the other benefit plan or the Plan Participant. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan has the right to recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

Right of Reimbursement and Subrogation

The Plan has certain special rights of subrogation and reimbursement that apply to all medical, dental, vision, and prescription drug benefits offered by the Plan. The Plan Administrator retains

discretionary authority to interpret and enforce this and all other plan provisions and the discretionary authority to determine the amount of the lien.

Plan Participant, his or her attorney, and/or a legal guardian of a minor or incapacitated individual agree that acceptance of the Plan's conditional payment of benefits is constructive notice of and agreement to all the terms in this Third Party Recovery Provision.

Defined Terms

"Condition" means an injury, illness, sickness, or other condition.

"Recovery" means moneys paid to the Plan Participant by way of judgment, settlement, arbitration, or otherwise to compensate for all losses caused by injuries or sickness whether or not said losses reflect medical, dental, vision, or prescription drug charges covered by the Plan.

"Refund" means repayment to the Plan for medical, dental, vision or prescription drug benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue the Plan Participant's claims for medical, dental, or prescription drug charges against the other person, including a third party and a third party's insurer.

Note that Plan Participant, as referenced in this Third Party Recovery section, includes both Employees and any Dependents covered by this Plan.

When this Provision Applies

The Plan Participant may incur medical, dental, vision, or prescription drug charges due to injuries caused by the act or omission of another party. In such circumstances, the Plan Participant may have a claim for the payment of the medical, dental, vision, or prescription drug charges against another party. This includes another party's insurer, or any other source on behalf of that party; any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage; any insurance policy from any insurance company or guarantor of a third party; worker's compensation or other liability insurance company; or any other person, entity, or source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage (all of the above in this sentence collectively referred to as "Coverage").

When the Plan pays for expenses that were either the result of the alleged negligence or which arise out of any claim or cause of action which may accrue against any party responsible for the injury or death of the Plan Participant or any dependent of the Plan Participant by reason of their eligibility for benefits under the Plan, the Plan has a right to equitable restitution. Accepting benefits under this Plan for those incurred medical, dental, or prescription drug expenses automatically entitles the Plan to a lien on any amount recovered by the Plan Participant whether or not designated as payment for medical expenses. The Plan's lien applies to any amount

recovered by the Plan Participant from another party or Coverage. These liens shall remain in effect until the Plan is repaid in full.

The Plan Participant agrees that the Plan will be immediately and first be reimbursed in full prior to the Plan Participant (or anyone else) receiving any monies recovered from another party or Coverage, or any other economic source; this provision applies regardless of any Plan Participant's fault or negligence and regardless of how any Plan Participant obtains recovery. In the event that another party or Coverage pays money directly to a Plan Participant or the Plan Participant's attorney, the Plan Participant and his or her attorney, for the exclusive benefit of the Plan, must hold any funds received as a result of any settlement, judgment, arbitration award, or otherwise, in constructive trust as soon as the funds are received. The Plan Participant is obligated to inform his or her attorney of the Plan's subrogation lien and to make no distributions which will in any way result in the Plan receiving less than the full amount of its lien without the written approval of the Plan. The Plan Participant must direct his or her attorney or attorneys or any other person holding monies on his or her behalf to pay over such monies to the Plan in the full amount that the Plan has paid on the Plan Participant's behalf, without any reduction in attorney's fees, legal fees, court costs, or any other costs or fees incurred in securing recovery, regardless of whether or not the Plan Participant is made whole.
The Plan may seek relief from anyone who receives settlement proceeds or amounts collected from judgments related to the condition. This relief may include, but is not limited to, the imposition of a constructive trust and/or an equitable lien. If the Plan Participant or any other beneficiary accepts payment from the Plan or has Plan benefits paid on the Plan Participant's behalf, that person does so subject to the provisions of the Plan, including the provisions described in this Right of Reimbursement and Subrogation Third Party Recovery section. Plan Participant, as well as any legal representative or guardian, shall be considered a constructive trustee with respect to any recovery received or that may be received, which was paid in consideration of any condition for which a party was responsible and which Plan Participant has received a benefit payment. Any such funds will be held in trust until the Plan's lien is satisfied.

Obligations of Plan Participant
The Plan Participant:

(1) Must repay to the Plan all benefits paid on his or her behalf by the Plan out of the recovery made from another party or Coverage; and
(2) Understands that the Plan has no obligation to share in the legal fees incurred by the Plan Participant or dependent in securing any third-party recovery (See below); and
(3) Understands that the Plan's right of reimbursement and subrogation will apply regardless of whether the Plan Participant is fully compensated or made whole economically; and
(4) Agrees that he or she will keep the Plan Administrator up to date and current regarding any developments between the Plan Participant and another party and their Coverage; and

(5) Agrees that he or she will not release any party or his, her, or its insurer, without prior written approval from the Plan, and will take no action which prejudices the Plan's reimbursement and subrogation right; and

(6) Agrees to refrain from characterizing any settlement in any manner so as to avoid repayment of the Plan's lien or right to reimbursement.

(7) Agrees to allow the Plan Administrator and contract administrator to share health information, including Protected Health Information, with third parties in order to enforce this provision.

The Plan has the right to the Plan Participant's full cooperation in any case involving the Plan Participant's recovery of medical, dental, vision, or prescription drug charges from another party or Coverage. In such cases, the Plan Participant is obligated to provide the Plan with whatever information, assistance, and records the Plan may require to enforce its rights in this provision.

Neither a Plan Participant, any member of any Plan Participant's family, nor anybody else at a Plan Participant's direction may do anything to harm the Plan's rights to subrogation and recovery. If a Plan Participant or an individual in the preceding sentence does not comply with any reasonable Plan request in this regard, the Plan may withhold benefits that otherwise may be due under the Plan, whether or not those benefits have anything to do with the subrogation, and a Plan Participant will be responsible to reimburse the Plan, in the Plan Administrator's discretion, for any costs incurred as a result of such action.

Amount Subject to Subrogation or Refund

The Plan may, but is not obligated to, take any legal action it sees fit against any person, party, entity, or otherwise to recover the benefits that the Plan has paid, including but not limited to intervening in any legal action of a Plan Participant and/or bringing a legal action against a Plan Participant, his or her attorney, and any party holding any proceeds relating to the Plan Participant. The Plan's exercise of this right will not affect the Plan Participant's right to pursue other forms of recovery unless the Plan Participant and his or her legal representative consent otherwise. Furthermore, the Plan Participant agrees that the Plan specifically has a priority over any attorney's fees, legal fees, court costs, or any other costs or fees incurred by the Plan Participant in recovering funds paid by another party Responsible Party or their Coverage. These attorney's fees, legal fees, court costs, or any other costs or fees are solely the responsibility of the Plan Participant. Additionally, the Plan Participant agrees that any attorney's fees, legal fees, court costs, or any other costs or fees incurred by the Plan or the Plan Sponsor in exercising the Plan's right to subrogation and reimbursement to recover funds paid by another party or Coverage are subject to the Plan's right of subrogation and will be included in the total amount reimbursed. **The Plan Participant clearly acknowledges that the Plan does not have any duty or obligation to pay a fee to the Plan Participant's attorney for the Plan Participant's attorney's services in making any recovery on behalf of the Plan Participant.**

Notwithstanding its priority to funds, the Plan's subrogation and refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical, dental, vision, or prescription drug charges as well as any other costs and fees associated with the enforcement of its rights under the Plan.

Death of Plan Participant
When the Plan pays benefits, funds recovered by the Plan Participant, and funds held in trust over which the Plan has an equitable lien, exist separately from the property and estate of the Plan Participant, such that the death of the Plan Participant, or filing of bankruptcy by the Plan Participant, will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement. In the event that the Plan Participant dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against another party or Coverage, the Plan's subrogation and reimbursement rights shall still apply.

Assignment of Rights
If the Plan Participant fails to pursue a claim against potentially responsible third parties, insurers, or any other person or entity and has accepted benefits under the Plan, the Plan is automatically assigned the Plan Participant's rights to recover payments from any third parties, insurers, or any other person or entity. This subrogation right allows the Plan to pursue any claim which the Plan Participant has against any third party, any insurer, or any other person or entity regardless of whether or not the Plan Participant chooses to pursue that claim. This subrogation right applies to any condition arising out of or related to any act or omission that caused or contributed to the Injury or Sickness for which such benefits are to be paid.

Minors
In the event the injured Plan Participant is a minor, the minor's parents and/or legal guardians agree to all of the terms set forth in this Third Party Recovery Provision.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

Plan Sponsor.
The Plan Sponsor will be one of the following: (1) the employer; (2) the employee organization; (3) a joint board of trustees; (4) an entity representing parties establishing or maintaining the Plan. For this Plan, the Employer is the Plan Sponsor. The Plan Sponsor shall be responsible for adopting the Plan and any amendments to the Plan and for creating a trust in which to hold the Plan assets. If the Plan Sponsor handles any of the Plan funds or other property, then the Plan Sponsor shall be required to be bonded with a fidelity bond.

Plan Administrator.
The Plan Administrator is an individual or a group of individuals usually named in the plan document that is responsible for the plan duties. The Plan Administrator may be an entity other than a natural person. If a Plan Administrator is not named in the plan document, then the Plan Sponsor is generally the Plan Administrator. For this Plan, the Employer is also the Plan Administrator. The Plan is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Employer to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise

removed from the position, Employer shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

Duties of the Plan Sponsor

(1) To formally adopt the Plan in writing and contains the provisions required under ERISA as well as other mandated provisions.
(2) To create a trust to hold all the Plan assets.
(3) To cause those employees that handle any of the Plan funds or other property to be bonded with a fidelity bond.

Duties of the Plan Administrator

(1) To administer the Plan in accordance with its terms.
(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
(3) To decide disputes which may arise relative to a Plan Participant's rights.
(4) To prescribe procedures for filing a claim for benefits and to review claim denials.
(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
(6) To appoint a Contract administrator to pay claims.
(7) To perform all necessary reporting as required by ERISA.
(8) To disclose to the Employee all necessary documents as required by ERISA.
(9) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
(10) To delegate to any person or entity such powers, duties and responsibilities, as it deems appropriate.

Plan Sponsor and Plan Administrator Compensation.
Both the Plan Sponsor and Plan Administrator serve **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

Fiduciary.
A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its' assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties.
A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) With care, skill, prudence and diligence under the given circumstance that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
(2) By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
(3) In accordance with the Plan documents to the extent that they agree with ERISA.

The Named Fiduciary.
A "named fiduciary" is the one named in the Plan or identified by the Employer and/or an employee organization as a fiduciary by a procedure specified in the Plan. A named fiduciary has authority to control and manage the operations and administration of the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment of the procedures; or
(2) The named fiduciary breached its fiduciary responsibility under Section 405 (a) of ERISA.

Contract Administrator is not a Fiduciary.
A Contract administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

SPECIAL PROVISIONS

Funding the Plan and Payment of Benefits

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage. The Plan Sponsor is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan. Funding is derived from the funds of the

Employer and/or contributions made by the covered Employees. The Employee will pay, through payroll deductions, any required contributions on a pre-tax basis under a pre-tax plan.

The level of any Employee contributions, if any, will be set by the Employer. Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefit Payments. Benefits are paid directly from the Plan through the Claims Administrator. The Claims Administrator does not contribute funds to pay benefits, nor does it have any liability to do so. Benefit payment checks issued to providers or participants are paid out of, and to the extent of, the funds received from the Employer and/or Employee contributions. The Claim Administrator's name may appear on the check; however, in no way should this be construed as any financial obligation on the part of the Claims Administrator.

Interpreting This Document
The use of masculine pronouns in this Summary Plan Description shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this Summary Plan Description are used for convenience of reference only. Covered Persons are advised not to rely on any provision because of the heading.

The use of the words, "you" and "your" throughout this Summary Plan Description applies to eligible or covered Employees and, where appropriate in context, their covered Dependents.

Plan is not an Employment Contract
The Plan is not to be construed as a contract for or of employment.

Clerical Error
Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

Amending and Terminating the Plan
If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust Agreement (if any). Only the Plan Administrator has the authority to amend the Plan. All amendments will be made via a written instrument signed by the Plan

Administrator. Any amendments to the Plan will be implemented on the first of the month following the date the amendment is approved and signed by the Plan Administrator.

Disposition of Trust Fund upon any termination
Upon termination of the Plan, the Trustee, in accordance with the Trust Agreement, shall apply all the remaining assets of the Trust Fund in a uniform and nondiscriminatory manner exclusively toward the provision of benefits and the administration of those there under for or on account of those persons enrolled in the Plan at the time of termination.

Conformity in Law
If any provision of this Plan is contrary to any federal, state, or local law to which it is subject, such provision is hereby amended to conform thereto.

Review Authority
The Plan Administrator shall have complete authority to review all denied claims for benefits under the Plan (including, but not limited to, the denial of certification of the medical necessity of hospital or medical treatment). In exercising its responsibilities, the Plan Administrator shall have discretionary authority 1) to determine whether and to what extent covered persons are eligible for benefits; and, 2) to construe disputed or doubtful Plan terms. The Plan Administrator shall be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

Legal Disputes
This Plan, and all matters relating either directly or indirectly to the operation and administration of this Plan, are governed exclusively by ERISA, which operates to pre-empt any and all state laws and regulations purporting to regulate this and similar plans. If the Plan Participant makes any legal claim against the Plan or any Plan Fiduciary, all benefits provided under the Plan shall cease as to the complaining employee, until such time as the employee's legal action is resolved. This provision shall not be read as providing any more rights than any legal judgment in favor of the employee and against the Plan or any Plan Fiduciary. Should the Plan Participant obtain a legal judgment against the Plan or the Plan Sponsor, the amount of any such judgment shall be offset against the amount of benefits previously paid to the Participant for the disputed claim.

Limitation of Legal Actions
No action at law or equity will be brought to recover under the Plan prior to the expiration of sixty (60) days after Proof of Loss has been filed, as required by the Plan Document, nor will any action be brought unless within two (2) years from the expiration of that time within which Proof of Loss is required by the Plan Document.

Fraud and Misstatements
All coverage provided under the Plan is based on the truthfulness of statements made to the Plan by the Plan Participants, either in a written enrollment form or otherwise. Coverage can be voided for any Plan Participant, and/or any or all members of that Participant's covered family unit, for any misrepresentation or fraudulent misstatement made to the Plan, the Plan Fiduciaries or Entrust by the Plan Participant or any or all members of that Participant's covered family unit.

Plan Participant/Provider Relationship
The Plan does not furnish covered services, but only helps pay for covered services Plan Participants receive. The Plan is not liable for any act or omission of any Provider. The Plan has no responsibility for a Provider's failure or refusal to give covered services to Plan Participants.

IMPORTANT NOTICES OF PLAN PARTICIPANT RIGHTS

Please carefully read the following important notices, which describe certain rights under Federal Law

Certain Employee Rights under ERISA
As a participant in the Braidwood Management Employee Benefit Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Received Information About Your Plan and Benefits
Examine, without charge, at the plan administrator's office and at other specified locations such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contract and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to a $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in party, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and a fee if, for example, it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

WHCRA ANNUAL NOTICE

The Women's Health and Cancer Rights Act of 1998 requires Braidwood Management, Inc., the Employer/Plan Sponsor, to notify you, as a participant or beneficiary of the Employer/Plan Sponsor, of your rights related to benefits provided through the plan in connection with a mastectomy. You as a participant or beneficiary have rights to coverage to be provided in a manner determined in consultation with your attending physician for:

(a) All stages of reconstruction of the breast on which the mastectomy was performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
(c) Prostheses and treatment of physical complications of the mastectomy, including lymph edema.

These benefits are subject to the plan's regular deductible and co-pay as shown in the Schedule of Benefits.

Keep this notice for your records and call Braidwood Management, Inc. for more information.

MINIMUM MATERNITY BENEFITS STATEMENT

Group health plans and health insurance issuers generally may not under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

CONTINUATION COVERAGE RIGHTS UNDER COBRA

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have options other than COBRA available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage? COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below.

COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee covered by the Plan, you will become a qualified beneficiary (i.e. you have a right to choose this continuation of coverage) if you lose your group health coverage under the Plan because either one of the following qualifying events occur:

- Your hours of employment are reduced, or
- Your employment terminates for any reason other than gross misconduct on your part

If you are the spouse of an employee covered by the Plan, you will become a qualified beneficiary (i.e. you have a right to choose this continuation of coverage) if you lose group health coverage under the Plan because any of the following qualifying events occur:

- The death of your spouse;
- A termination of your spouse's employment for reasons other than his or her gross misconduct;
- Reduction in your spouse's hours of employment;
- Divorce or legal separation from your spouse; or
- Your spouse becomes enrolled in Medicare (Part A, Part B, or both).

Your dependent children covered by the Plan will become a qualified beneficiary (i.e. you have a right to choose this continuation of coverage) if they lose coverage under the Plan because any of the following qualifying events occur:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment is terminated for any reason other the gross misconduct on his or her part;
- The parents become divorced or legally separated;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both); or
- The dependent child ceases to be eligible for coverage under the Plan as a "dependent child."

When is COBRA Coverage Available? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of

employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the Employer is responsible for notifying the Plan Administrator of the qualifying event within thirty (30) days of any of these events. Similar rights may apply to certain retirees, spouses, and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage.

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

ENTRUST, INC.
Attn: COBRA Dept.
22322 Grand Corner Drive, Suite 200
Katy, TX 77494

Each covered Employee or Qualified Beneficiary is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

1. Notice of the occurrence of a Qualifying Event that is a divorce of a covered Employee (or former Employee) from his or her spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA continuation coverage with a maximum duration of 18 (or 29) months;
4. Notice that a Qualified Beneficiary entitled to receive COBRA continuation coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of COBRA continuation coverage; and
5. Notice that a Qualified Beneficiary, with respect to whom a notice described in the bulleted item above has been provided, has subsequently been determined by the SSA to no longer be disabled.

Deadline for providing the notice

For Qualifying Events described in (1), (2) or (3) above, the notice must be furnished by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described above, the notice must be furnished by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of COBRA continuation coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

- The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed), or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage is lost, and if you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan, or if you are extending COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

Who can provide the notice?

Any individual who is the covered Employee (or former Employee), a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee) or Qualified Beneficiary, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Required contents of the notice

The notice must contain the following information:

- Name and address of the covered Employee or former Employee;
- If you already are receiving COBRA continuation coverage and wish to extend the maximum coverage period, identification of the initial Qualifying Event and its date of occurrence;
- A description of the Qualifying Event (for example, divorce, cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the

covered Employee or former Employee, disability of a Qualified Beneficiary or loss of disability status);

- In the case of a Qualifying Event that is divorce, name(s) and address(es) of spouse and Dependent child(ren) covered under the Plan, date of divorce, and a copy of the decree of divorce ;
- In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of spouse and Dependent child(ren) covered under the Plan;
- In the case of a Qualifying Event that is a dependent child's cessation of Dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible Dependent (for example, attained limiting age, lost student status, married or other);
- In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of spouse and Dependent child(ren) covered under the Plan;
- In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
- In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
- A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage, or extension of such coverage, will be available until the copy of the decree of divorce or the SSA's determination is provided.

If the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the covered Employee (or former Employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

How is COBRA Coverage Provided? When the Plan Administrator receives notice that a qualifying event has occurred, the Plan Administrator will in turn offer COBRA continuation coverage to each of the qualified beneficiaries. Under the law, you have at least 60 days from the date you would lose coverage, because of a qualifying event described above, to inform the Plan Administrator that you want continuation coverage.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their covered spouses,

and parents may elect on behalf of their covered children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

If you do not choose COBRA continuation coverage in a timely manner, your group health coverage will end. Not choosing COBRA continuation coverage may cause a break in your continued coverage.

If you choose continuation coverage, the Employer is required to give you coverage, which as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for thirty-six (36) months if the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), the employee's divorce or legal separation from his or her spouse, or a dependent child losing eligibility as a dependent child.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee can last until 36 months after the date of Medicare entitlement. However, if the qualifying event is the employee's termination of employment (for other than gross misconduct), whether voluntary or involuntary, or a reduction in the employee's hours of employment, then the required continuation coverage period is eighteen (18) months. Below are two ways that in which the eighteen (18) month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage: If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum period of twenty-nine (29) months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within sixty (60) days of the date of the determination and before the end of the eighteen (18) month period of COBRA continuation coverage. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

Second qualifying event extension of 18-month period of continuation coverage: If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to an additional 18 months of COBRA continuation coverage, for a maximum of thirty-six (36) months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare

(Part A, Part B, or both), or gets divorced or legally separated, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child, but only if the event would have caused the dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within sixty (60) days of the second qualifying event.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

How much does COBRA continuation coverage cost? Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

Once COBRA continuation coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated.

Other Important COBRA Information: A child who is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator with 30 days of the birth or adoption.

The law also provides that continuation coverage may be cut short for any of the following reasons:

- The Employer no longer provides group health coverage to any of its employees;
- The premium for continuation coverage is not paid on time;
- The qualified beneficiary becomes covered under another group health plan after electing to participate in a continuation coverage plan;
- The qualified beneficiary becomes entitled to Medicare after electing to participate in a continuation coverage plan; or
- The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual in no longer disabled.

If You Have Questions: Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional or District EBSA Offices are available through EBSA's Website.)

Additional Information

Additional information about the Plan and COBRA continuation coverage is available from the Plan Administrator, who is:

Braidwood Management, Inc.
20214 Braidwood Drive
Katy, Texas 77450

Current Addresses

In order to protect your family's rights, you should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

HIPAA PRIVACY USES AND DISCLOSURES

The Health Insurance Portability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (referred to herein as the "HIPAA Privacy Rule") requires that the Plan protects the confidentiality of your Protected Health Information ("PHI"). A complete description of your rights under the HIPAA Privacy Rule is available upon request from the Employer by contacting the Privacy Official.

This amendment is intended to bring the Plan into compliance with the requirements of the HIPAA Privacy Rule by establishing the extent to which the Employer will receive, use and/or disclose PHI. According, the Plan is hereby amended as follows:

A. THE PLAN DESIGNATION OF PRIVACY OFFICIAL

The Plan has designated that it is a group health plan within the meaning of the HIPAA Privacy Rule. The Plan designates the Human Resources Director as the Privacy Official, to take all actions required to be taken by the Plan in connection with the Privacy Rule.

B. REQUIRED CERTIFICATION OF COMPLIANCE BY EMPLOYER

Except as provided below with respect to the Plan's disclosure of summary health information the Plan will (a) disclose PHI to the Employer or (b) provide for or permit the disclosure of PHI to the Employer by a Business Associates, Subcontractor or other plan vendor with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Employer) that:

1. The Plan has been amended to establish the permitted and required uses and disclosures of such information by the Employer, consistent with the HIPAA Privacy Rule;
2. The Plan has been amended to incorporate the Plan provisions set forth in this Amendment; and
3. The Employer agrees to comply with the Plan provisions as modified by this Amendment.

C. PERMITTED USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

1. The Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted by the HIPAA Privacy Rule. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and healthcare operations.
2. The Plan, and any Business Associate acting on behalf of the Plan, will disclose PHI to the Employer only to permit the Employer to carry out plan administration functions. Such disclosures will be consistent with the provisions of this Amendment.
3. All disclosures of PHI by the Plan or the Plan's Business Associate will comply with the restrictions and requirements set forth in this Amendment and the HIPAA Privacy Rule.
4. The Plan, and any Business Associate acting on behalf of the Plan, may not disclose, and may not permit the disclosure of, PHI to the Employer for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

D. THE PLAN WILL USE AND DISCLOSE PHI AS REQUIRED BY LAW AND AS PERMITTED BY AUTHORIZATION OF THE PARTICIPANT OR BENEFICIARY

The Plan will disclose PHI when required by law, and when permitted by an authorization from the individual to which the PHI relates, but only to the extent allowed under the authorization.

E. DISCLOSURE OF PHI BY EMPLOYER

The Employer agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan or as permitted or required by the HIPAA Privacy Rule;
- Ensure that any agents, including Business Associates or Subcontractors, to whom the Employer provides PHI received from the Plan, or whom creates PHI on behalf of the Plan, agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;

- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for in the Plan (as amended) and in the HIPAA Privacy Rule of which it becomes aware;
- Make PHI available to an individual in accordance with the HIPAA Privacy Rule's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with the HIPAA Privacy Rule;
- Make and maintain an accounting so that it can make available those disclosures of PHI that it must account for in accordance with the HIPAA Privacy Rule;
- Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the Secretary of U.S. Department of Health and Human Services for the purposes of determining the Plan's compliance with the HIPAA Privacy Rule;
- If feasible, return or destroy all PHI received from the Plan, or the Business Associate or the Subcontractor on behalf of the Plan, that the Employer still maintains in any form, and retain no copies of such PHI after such PHI is no longer needed for the purpose for which disclosure was made. If, however, such returned or destruction is not feasible, the Employer will limit further uses or disclosure of the PHI to those purposes that make the return or destruction of the PHI infeasible;
- The Employer will ensure that the required adequate separation, as provided in this Amendment, is established and maintained.

F. ADEQUATE SEPARATION BETWEEN THE PLAN AND THE EMPLOYER

In accordance with HIPAA Privacy Rule, only the following employee(s) or classes of employees may be given access to PHI to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule:

- TRUSTEE (S) of the Plan
- Human Resources Director

G. LIMITATIONS OF PHI ACCESS AND DISCLOSURE

The persons described in section F may only have access to and use and disclose of PHI relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Employer performs for the Plan. These individuals will have access to PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Employer) for any use or disclosure of PHI in violation of, or noncompliance with, the provisions of this Amendment or the HIPAA Privacy Rule.

H. REPORT OF VIOLATION OR NONCOMPLIANCE

The Employer will promptly report any violation or noncompliance described in section G to the Plan and will cooperate with the Plan to correct the violation or noncompliance to impose

appropriate disciplinary action and/or sanctions, and to mitigate any harmful effect of the violation or noncompliance.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 C.F.R. § 164.504(a)), the Plan Sponsor agrees to:

- Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 C.F.R. § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI; and
- Report to the Plan any Security Incident of which it becomes aware.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

USERRA

If you are absent from employment because you are in the uniformed service, you may elect to continue your coverage under this Plan for up to 24 months. To continue your coverage, you must comply with the terms of the Plan, including election during the Plan's Open Enrollment Period, and pay your contributions, if any. In addition, USERRA also requires that, regardless of whether you elected to continue your coverage under the Plan, your coverage and your Dependents' coverage be reinstated immediately upon your return to employment, so long as you meet certain requirements contained in USERRA. Contact your Employer for information concerning your eligibility for USERRA and any requirements of the Plan.

"Uniformed Services" means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

FMLA

The Plan will at all times comply with FMLA. During any leave taken under FMLA, an Employee may maintain coverage under this Plan on the same conditions as if he or she had been continuously employed during the entire leave period. To continue coverage during FMLA, the Employee must comply with the terms of the Plan, including election during the Plan's annual Open Enrollment Period, and pay any required contributions. Contact the Employer for information concerning eligibility for FMLA and any requirements of the Plan.

PRESCRIPTION DRUG COVERAGE AND MEDICARE PART D

Non-Creditable Coverage –Plan B

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Braidwood Management Employee Benefit Plan Trust and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Braidwood Management, Inc. has determined that the prescription drug coverage offered by the Braidwood Management Employee Benefit Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Braidwood Management Employee Benefit Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from Braidwood Management Employee Benefit Plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should

compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you decide to drop your current coverage with Braidwood Management Employee Benefit Plan, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under Braidwood Management Employee Benefit Plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under Braidwood Management Employee Benefit Plan is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Plan's coverage will be affected. Braidwood Management Employee Benefit Plan Trust provides prescription coverage for certain covered medications. The prescription coverage cost for Plan B will be applied toward the deductible and coinsurance. Further details of your prescription coverage can be found in your Summary Plan Description.

If you do decide to join a Medicare drug plan and drop your current Plan's coverage, be aware that you and your dependents will not be able to get this coverage back until the open enrollment period under the Braidwood Management Employee Benefit Plan.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Braidwood Management Employee Benefit Plant changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	December 1, 2018
Name of Entity/Sender:	Braidwood Management, Inc.
Contact--Position/Office:	Entrust, Inc., Claim Administrator
Address:	22322 Grand Corner Drive, Suite 200 Katy, TX 77494
Phone Number:	(281) 368-7878 Attn: Customer Service

APPENDIX A - GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded welfare plan and the administration is provided through a third party Contract administrator.

This plan is funded by employer and employee contributions. Please see your benefit guide for the current contribution schedule. The Plan is not insured.

PLAN NAME:	Braidwood Management Employee Benefit Plan Trust
PLAN NUMBER:	501
GROUP NUMBER:	749000
TAX ID NUMBER:	76-0465304
TRUST ID NUMBER:	27-7030991
PLAN EFFECTIVE DATE:	December 1, 2018
PLAN YEAR:	December 1 – November 30
EMPLOYER (PLAN SPONSOR) INFORMATION:	Braidwood Management, Inc. 20214 Braidwood Drive Katy, Texas 77450
TRUSTEE(S):	Catherine Burnett Monica Luedecke (Same address as Plan Sponsor)
NAMED FIDUCIARY:	Same as Above
AGENT FOR SERVICE OF LEGAL PROCESS:	See Trustee(s)
EHB BENCHMARK STATE:	Utah
CLAIMS / CONTRACT ADMINISTRATOR:	Entrust, Inc. 22322 Grand Corner Drive, Suite 200 Katy, TX 77494 (281) 368-7878

PREFERRED PROVIDER ORGANIZATION (PPO)

First Health Network

3200 Highland Avenue
Downers Grove, Illinois 60515
Tel. (800) 226-5116
www.myfirsthealth.com